# *Effective HIV Interventions and Strategies*

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# Table of Contents

## 1. How to Use Social and Behavioral Theory in Your HIV Prevention Programs Going From Theory to Practice

Like the CDC, the State Planning Group strongly recommends using HIV prevention interventions that are based on social and behavioral theory. CDC also stipulates these interventions must have been proven to be effective through a thorough evaluation of the program. If your desired population fits into the intervention chosen, you may replicate the intervention without any changes and feel confident that the outcome of the intervention will have the same positive outcome as the original intervention. However, if for any reason you must adapt the intervention, you **MUST** maintain the core elements of the originally evaluated intervention. Fortunately, if you have modeled your program after an **evidenced-based** intervention, ensuring you have maintained the core elements, your program will likely be effective in reducing the risk of HIV transmission.

**Evidenced-based** means that the behavioral, social, and structural interventions that are relevant to HIV risk reduction, have been tested using a methodologically rigorous design, and have been shown to be effective in research settings.

These evidence or science-based interventions have been evaluated using behavioral or health outcomes; have been compared to a control/comparison group(s) (or pre-post data without a comparison group (s) if a policy study); had no apparent bias when assigning persons to interventions or control groups or were adjusted for any apparent assignment bias; and, produced significantly greater positive results when compared to control/comparison group(s), while not producing negative results**.**

**For example**, let's say you want to institute Safety Counts. This is a cognitive-behavioral intervention to reduce HIV risk among active drug users. The intervention is a GLI (with ILI and SCO activities). The literature states that you are able to use this intervention with HIV-positive or HIV- negative active drug users. If you need/want to adapt this intervention, you **MUST** maintain the core elements. The intervention also contains key characteristics that could be changed based on the needs/input of your population. The core elements of this intervention are as follows:

1) Two group sessions (identify the client's HIV risk and current stage of change, hear risk reduction stories, set personal goal and identify first step to reduce HIV risk).

2) One individual counseling session (discuss/refine risk-reduction goal, assess client's needs and provide indicated referrals to C&T and medical/social services).

3) Two (or more) group social events (share meal and socialize, participate in planned HIV related risk-reduction activities, and receive reinforcement for personal risk reduction).

4) Two (or more) follow-up contacts (review client's progress in achieving risk-reduction goal, discuss barriers encountered, identify concrete next steps and discuss possible barriers/solutions, and make referrals to C&T and medical/social services).

The key characteristics that can be changed are:

| KEY CHARACTERISTICS | HOW THEY CAN BE CHANGED |
|---|---|
| Provide planned HIV-related risk reduction component in the group social event. | The component can be in the form of educational games, workshops, roundtables, or a featured speaker. The form used should be based on community involvement in the intervention planning process. |
| The Safety Counts kit comes with a video of risk-reduction success stories. | Make your own video, produce audio tapes, written stories or arrange live testimonials describing personal risk-reduction successes using the local IDU population. |
| Individual contracting sessions are 15-30 minutes in length. | Increase the length of the contracting sessions based on community and participant needs/input. |

## 2. Defining Intervention and Strategy

**Intervention** - a specific activity (or set of related activities) intended to change the knowledge, attitudes, beliefs, behaviors, or practices of individuals and populations, to reduce their health risk. An intervention has a distinct process, outcome objectives, and a protocol outlining the steps for implementation.

**Strategy** – a strategy is a particular method or approach consistently used in the course of the intervention. An example of a strategy would be to use peers to provide the instruction during a group level intervention presentation.

Regardless if you use an evaluated intervention, which demonstrates effectiveness or one that you are creating using a scientifically based theory, **there are five important things that you must know about your population**.

1. What community or prioritized population are you trying to reach (MSM, IDU, Heterosexual)?

2. What specific behaviors place them at risk (MSM engaging in unprotected anal intercourse, IDUs sharing needles and/or having unprotected sex with multiple partners; those engaging in unprotected intercourse with multiple partners; or heterosexually identified MSM engaging in unprotected anal intercourse)?

3. What factors impact their risk taking behavior (risk appraisal – stereotype who is at most risk, fatalism, hierarchy; self-protection – self-efficacy expected outcome; emotion and arousal: relationship issues – gender roles, peer pressure, interpersonal power dynamics; structural and environmental factors – racism, sexism, and social policy)?

4. What intervention type best addresses these factors? and

5. What theories or models best address these factors

3. **<u>Quick Guide to Intervention Types (Health Education and Risk Reduction)</u>**
(http://www.cdc.gov/hiv/aboutdhap/perb/guidance/chapter3.htm)

**INTERVENTION TYPE DEFINITIONS**

| INTERVENTION TYPE | INCLUDES | EXCLUDES |
|---|---|---|
| **A. Individual-Level Intervention (ILI)** | Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. **(DOH has added the stipulation that a single session individual level intervention must be research based and not just theory based)**. | Outreach and prevention case management. Each constitutes its own category. Also excludes HIV counseling and testing. |
| **B. Group-Level Intervention (GLI)** | Health education and risk reduction counseling provided in groups of varying sizes. GLIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. Just so there is not any misunderstanding what group means, group DOES NOT mean a gathering of two or more. **(DOH has added the requirement that the GLI must contain skills building and have multiple sessions)**. | Excludes group education that lacks a skills component (e.g., information only as "one short" presentations). These types should be included in the Health Communication/Public Information category. |

| INTERVENTION TYPE | INCLUDES | EXCLUDES |
|---|---|---|
| **C. Outreach** | HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leaders. **In the new *HIV Prevention Community Planning Guidance of 2003*,** pg 42, (www.cdc.gov/HIV/PUBS/HIV-cp/appendixD.htm). **CDC emphasizes that a major purpose of outreach activities is to encourage those at high risk to learn their HIV status.** | Excludes condom or material drop offs and other outreach activities that lack face-to-face contact with a client. |
| **D. Prevention Case Management (PCM)** | Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage. | Excludes one-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage. |
| **E. Partner Counseling and Referral Services (PCRS)** | A systematic approach to notify sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services. | Excludes HIV counseling and testing which is reported in its own category. |

| INTERVENTION TYPE | INCLUDES | EXCLUDES |
|---|---|---|
| **F. Health Communication/ Public Information (HC/PI)** | The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services<br><br>**Electronic Media**: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcast, infomercials, etc., which reach a large-scale (e.g., city, region, or statewide) audience.<br><br>**Print Media:** These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.<br><br>**Hotline:** Telephone service (local or toll free) offering up-to-date information and referral to local services, e.g., counseling/testing and support services<br><br>**Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide responsive information service to the general public as well as high-risk populations.<br><br>**Presentations/Lectures:** These are information-only activities conducted in-group settings; often called "one-shot" education interventions.<br><br>**Social Marketing:** Uses techniques adapted from commercial marketing to identify specific audiences called segments and their perceived needs, and then constructs a program of services, support, and communication to meet those needs. | Excludes group interventions with a skills building component, which constitutes its own intervention category. |

| INTERVENTION TYPE | INCLUDES | EXCLUDES |
|---|---|---|
| **G. Counseling, Testing and Referral (CTR)** | An individualized intervention of usually two sessions (pre-test and post-test aimed at learning current serostatus; increasing understanding of HIV infection; assessing risk of HIV acquisition and transmission; negotiating behavior change to reduce risk of acquiring or transmitting HIV; and providing referrals for additional medical, preventive, and psychosocial needs. | HIV counseling and testing is more than an information session; however, it is not therapy.<br><br>This intervention is closely linked with Partner Counseling and Referral Services (PCRS). |
| **Other Interventions** | Category to be used for those interventions that cannot be described by the definitions provided for the other six types of interventions (example forms A-F). This category includes community level interventions (CLI).<br><br>CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions. **Based on DOH's interpretation of Chapter 3: Intervention and Population Definitions,** (www.cdc.gov/hiv/aboutdhap/perb/guidance/chapter3.htm) **pages lll 9 – lll 10 of the 2002 version of** "***Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC-Funded HIV Prevention Programs***" (www.cdc.gov/hiv/aboutdhap/perb/guidance.htm) . **The organizations receiving CDC funds have been asked to separate the CLI "programs" into specific intervention types. This allows for better measuring of the activities that take place.** | Excludes any intervention that can be described by one of the existing categories. |

# Effective Interventions for HIV Positive Persons

## Literature Summary

| **Individual-Level** | | |
|---|---|---|
| Padian, N.S., O'Brien, T.R., et al. (1993) Prevention of Heterosexual Transmission of Human Immunodeficiency Virus Through Couple Counseling. *Journal of Acquired Immunodeficiency Syndrome*. 6(9): 1043-8 | | |
| HIV+ Heterosexual | 144 HIV infected individuals and their heterosexual partners. Every six months, each member of the couple was interviewed separately by a staff member to obtain demographic and behavioral information and offer couple counseling. Couples were counseled together for first session on how to purchase, store and use condoms; how to refrain from practicing anal sex; how to choose abstinence; and how not to enter into sexual relations with new partners. | The intervention was effective at improving safer sex behaviors, with change occurring between initial enrollment and the first follow up. 85% of the couples who did not use condoms at initial enrollment did so by the most recent follow-up. During the intake interview, 49% reported condom use. During the 1st follow-up, 88% reported condom use. Other behavior changes were also made. |

| | | |
|---|---|---|
| Fisher, D., Ryan, R., et al. (1999). Using a community partnership and motivational interviewing to serve HIV+ gay and bisexual men. *National HIV Prevention Conference, 1999* [Abstract no. 680]. | | |
| HIV+ | Preliminary report. 107 HIV+ MSM who had anal sex in preceding 4 months with a male partner. Using motivational interviewing, assess values, beliefs, attitudes, and details on 4 most recent anal sex partners. In discussion, highlight discrepancies between values, beliefs, and risky sexual behaviors. | Six-month follow-up data show a 31% reduction in the proportions of participants reporting unprotected anal sex with a partner of negative or unknown serostatus. |

| **Prevention Case Management** |
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| The CDC has endorsed Prevention Case Management (PCM) as an effective intervention to reach HIV positive and/or very high-risk HIV negative persons. PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. PCM provides client-centered, multiple-session HIV risk reduction counseling while using the service brokerage of traditional case management to address competing needs that may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use, mental health, adherence issues, social and cultural factors, and physical health problems. While PCM has yet to be rigorously evaluated, intensive case management interventions for clients with multiple, complex problems have been shown to be effective in other health fields. **CDC PCM Guidance September 1997** http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm. **Literature Review** – www.cdc.gov/hiv/pubs/pcml/pcml-doc.htm. **Acronyms** – www.cdc.gov/hiv/pubs/pcmg/pcmg-acr.htm |

# Effective Interventions for HIV Positive Persons

| **Group-Level** | | |
|---|---|---|
| Fogarty, L.A., Heilig, C.M., Armstrong K, et al. (2001). Long-Term Effectiveness of a Peer-Based Intervention to Promote Condom and Contraceptive Use among HIV-Positive and At-Risk Women. *Public Health Reports* 116: S103-S119. | | |
| HIV+ women | HIV infected women in one study (N=322, Baltimore) and women at high risk for HIV infection in a second study (N=1289, Philadelphia) assigned to a standard or enhanced HIV prevention treatment group. Standard intervention was access to Title X comprehensive health services throughout study. The enhanced intervention added support groups and one-on-one contacts with peer advocates tailored to clients' needs. Based on Stage of Change Theory. | Measurements at baseline, 6 months, 12 months, and 18 months. For HIV infected women, enhanced group had improved consistency in condom use, increased perceived advantages of condom use, and increased self-efficacy. For women at-risk, enhanced group showed no sustained advantage over standard group. |

| Coates, T.J., McKusick, L., et al. (1989). Stress-reduction training changed numbers of sexual partners but not immune function in men with HIV. *American Journal of Public Health* 79: 885-7. | | |
|---|---|---|
| HIV + MSM | 64 HIV+ gay men randomly assigned to 1) eight 2-hour weekly group stress reduction training session plus one all day retreat, or 2) a 2 month wait-list control. | At 2-month follow-up, experimental group had fewer sexual partners in the past month than control group (1.1 vs. 2.3). |

| Kalichman, S.C., Rompa, D., Cage, M., et al. (2001). Effectiveness of an Intervention to Reduce HIV Transmission Risks in HIV-Positive People. *American Journal Preventive Medicine* 21(2): 84-92. | | |
|---|---|---|
| HIV+ and African-American<br><br>*"Health Relationships"* | 233 men and 99 women living with HIV/AIDS randomly assigned to receive either 1) a five-session group intervention focused on strategies for practicing safer sexual behavior, or 2) a five-session, contact-matched, health-maintenance support group (standard-of-care comparison). 74% of participants were African-American. Based on Social Cognitive Theory, emphasizing building behavioral skills, enhancing self-efficacy for practicing risk-reduction behaviors, promoting intentions to change, and developing strategies for change. Framed intervention content within context of managing stress related to HIV disclosure and practicing safer sexual behavior. The five 120-minute sessions were delivered at the rate of two per week using gender-specific presentations.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Outcomes measured immediately post intervention, 3 months, and 6 months. 78% retention at 6 months. At 6-month follow-up, intervention group reported fewer HIV negative partners, less unprotected anal and vaginal intercourse, and greater condom use. |

# Effective Interventions for HIV Positive Persons

| **Group-Level (cont.)** | | |
|---|---|---|
| Kelly, J.A., St. Lawrence, J.S., et al. (1989). Behavioral intervention to reduce AIDS risk activities. *Journal of Consulting and Clinical Psychology* 57: 60-7. | | |
| HIV +, negative, or unknown status high-risk MSM<br><br>*"Many Men, Men Voices"* | 104 participants randomly assigned to 1) 12 weekly sessions, 75-90 min small group counseling which provided AIDS risk information, behavioral self-management, assertiveness training, and relationship-building skills or 2) a wait-list control.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Skills training resulted in less unprotected anal sex (mean=2.3 for experimental group; 3.3 for control group) and higher condom use during anal sex in the past 4 months (experimental group used condoms during 66% of all anal episodes; 19% for control group). Behavior change maintained at 8-month follow-up |

| Kelly, J.A., St. Lawrence, J.S., et al. (1990). A skills-training group intervention model to assist persons in reducing risk behaviors for HIV infection. *Education and Prevention* 2: 24-35. | | |
|---|---|---|
| HIV +, unknown, status, or negative high-risk MSM | Purpose of study to evaluate impact of more abbreviated intervention than Kelly et al. (1989) above. 15 participants received 7 small group sessions, 60-90 min each. Covered AIDS risk information, behavioral self-management, assertiveness training, pride and support issues. One 3-month follow-up booster session. | At 8-month follow-up, UAI in past 4 months fell from .93 to .21 mean occurrences. Proportion of all intercourse occasions where condoms used increased from 72% to 90%. Risk index (risky practices x no of partners) decreased from 4.7 to 1.4. |

| Rotheram-Borus, M.J., Lee, M.B., Murphy, D.A., et al. (2001) Efficacy of a prevention intervention for youths living with HIV. *American Journal of Public Health* 91: 400-5. | | |
|---|---|---|
| Youth/ HIV+ (Mostly MSM)<br><br>*"Teens Linked to Care"* | 310 youths, 72% male (mostly MSM) and 28% female, aged 13-24, 27% African-Am and 37% Latino. Study conducted at 9 adolescent clinical care sites in 4 cities. Assigned by small cohort to a 2-module ("Stay Healthy" and "Act Safe") intervention with 23 sessions or to a control condition. In intervention condition, 73% attended at least 1 session. Assessment of module 1 conducted 6 months after completion. Assessment of module 2 conducted 3 months after completion. Cohorts mixed according to sex. (Detailed manual available on web at http://chipts.ucla.edu.) Had difficulty getting youths to attend sessions.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Following "Stay Healthy" module, number of positive lifestyle changes and active coping styles increased among intervention females vs. control. Social support coping increased for all intervention clients vs. controls. Following "Act Safe" module, intervention youths reported 82% fewer unprotected sexual acts, 45% fewer sexual partners, 50% fewer HIV negative partners, and 31% less substance use than controls. |

# Effective Interventions for HIV Positive Persons

| **Group-Level (cont.)** | | |
|---|---|---|
| Rhodes, F., Wood, M.M., Hershberger, S. (2000) A cognitive-behavioral intervention to reduce HIV risk among active drug users. In staying negative in a positive world: HIV prevention strategies that work (pp. 113-124). Sacramento: California Department of Health Services, Office of AIDS. | | |
| HIV + or negative IDUs<br><br>*"Safety Counts"* | This intervention (*Safety Counts*) is aimed at reducing high-risk drug use and sexual behaviors of injective drug and crack cocaine users not in treatment. This seven-session behaviorally focused intervention includes both structured and unstructured psychoeducational activities. These sessions were both in group and individual settings over four to six months.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Participants were more than 2.5 times more likely to self-report an increase in condom use at follow-up (5-9 months following enrollment). They were also more likely to report a reduction in the number of times they inject and more likely to test negative for opiates through urinalysis. Plus, they were also more likely to enter drug treatment. |

| Margolin, A., Avants, S.K., Warburton, L.A., Hawkins, K.A., Shi, J. (2003). A randomized clinical trial of a manual-guided risk reduction intervention for HIV-positive injecting drug users. *Health Psychology*, 22(2) 223-228. | | |
|---|---|---|
| HIV + IDUs<br><br>*"Holistic Harm Reduction Program (HHRP)"* | This intervention uses a 12-session, manual-guided, group level program to reduce harm, promote health, and improve quality of life. The program is based on the Information, Motivation, Behavior (IMB) model of behavior change. In this program, HIV positive IDUs are viewed as autonomous individuals responsible for making informed choices concerning behaviors that pose risk to themselves and others. Activities in this intervention are designed to address clients as complex human beings is search of physical emotional, social, and spiritual well-being. (HHRP training manuals and other intervention materials – http://www.info.med.yale.edu/psych/3s/training.html)<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Participants in this intervention exhibited many significant improvements. They included: measures of addiction severity, harm reduction behaviors, harm reduction knowledge, motivation, behavioral skills, and quality of life. After three months, the participants displayed a greater improvement in behavioral skills and showed a continued decrease in addiction severity and risk behavior. Members in a control group did not maintain gains. |

# Effective Interventions for HIV Positive Persons

| **CDC Partner Notification Guidance** - www.cdc.gov/hiv/partners/interim/partnercounsel.htm<br>**Procedural Guidance Intervention –** http://www2a.cdc.gov/hivpra/documents/Attachments/cbofinal/Pages from CBOProcedures_15Dec03_FinalDraft_10.pdf | | |
|---|---|---|
| Partner Counseling and Referral Services to Identified Persons with Undiagnosed HIV---North Carolina. MMWR December 5, 2003/52 (48); 1181-1184 | | |
| | In 1989, North Carolina Department of Health and Human Services began offering PCRS to clients who tested positive in confidential and anonymous testing venues. HIV infection became reportable in 1990 and anonymous testing was discontinued in 1997. A trained disease intervention specialist (DIS) completed six important steps. All notified partners received risk reduction counseling and appropriate referrals. | Data collected from 2001 revealed a total of 1,603 persons were newly reported to have HIV infections. DIS were assigned to conduct PCRS with 1,580 (99%) index clients, 1,378 (87%) were located and PCRS identified 1,532 sex or needle sharing partners. 1,359 partners were located and notified of their possible exposure to HIV. After PCRS, from those who not previously testing positive for HIV, 108 newly tested partners were diagnosed HIV positive. |

**No reviews on Mass & Other Media, Social Marketing, Hotlines, and Clearinghouse.**

# Effective Interventions for Men Who Have Sex With Men

## Literature Summary

| **Individual-Level** | | |
|---|---|---|
| Dilley, J.W., Woods, W.J., Sabatino, J., et al. (2002). Changing Sexual Behavior Among Gay Male Repeat Testers for HIV: A Randomized, Controlled Trial of a Single-Session Intervention. *JAIDS* 30: 177-186. | | |
| Repeat testers | Randomized, controlled counseling intervention. Conducted at anonymous testing site in San Francisco. N=248 MSM with history of at least one previous negative HIV test result and self-reported UAI in last 12 months with partners of unknown or discordant status. Intervention component focused on self-justifications (thoughts, attitudes, or beliefs that allow the participant to engage in high-risk behaviors) at most recent UAI. Two intervention groups received standard HIV test counseling plus the intervention (one group also had sexual diary). Two control groups received only standard HIV test counseling (one group also had sexual diary). Counselors in intervention arm were licensed mental health professionals. Intervention counseling occurred between pre-test and post-test session. Intervention session lasted about 1 hour. | Compared to control participants, intervention participants reported decreased UAI with non-primary partners of unknown or discordant HIV status at 6 and 12 months (from 66% to 21% at 6 months and to 26% at 12 months). Overall retention at 6 and 12 months was 87% and 83%, respectively. |

| **Prevention Case Management** |
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| The CDC has endorsed Prevention Case Management (PCM) as an effective intervention to reach HIV positive and/or very high-risk HIV negative persons. PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. PCM provides client-centered, multiple-session HIV risk reduction counseling while using the service brokerage of traditional case management to address competing needs that may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use, mental health, adherence issues, social and cultural factors, and physical health problems. While PCM has yet to be rigorously evaluated, intensive case management interventions for clients with multiple, complex problems have been shown to be effective in other health fields. **CDC PCM Guidance September 1997** http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm. **Literature Review** – www.cdc.gov/hiv/pubs/pcml/pcml-doc.htm. **Acronyms** – www.cdc.gov/hiv/pubs/pcmg/pcmg-acr.htm |

# Effective Interventions for Men Who Have Sex With Men

| **Group-Level** | | |
|---|---|---|
| Choi, K-H., Lew, S., Vittinghoff, E., et al. (1996). The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. *AIDS* 10: 81-87. | | |
| POC (API) | Brief group counseling for self-identified gay API in SF. N = 329 (208 intervention, 121 control). Randomized in single-session, 3-hr skills training group or wait-list control. 4 components: development of positive identity and social support, safer sex education, eroticizing safer sex, negotiation. | Baseline and 3-month follow-up. 46% reduction in expected number of partners at follow-up for intervention group. Chinese and Filipino men reduced UAI by more than 50%. |

| Rotheram-Borus, M.J., Reid, H., et al. (1994) Factors mediating changes in sexual HIV risk behaviors among gay and bisexual male adolescents. *American Journal of Public Health* 84:1938-1946. | | |
|---|---|---|
| Youth/ Street | 136 participated, age range 14-19. 20-session intervention, 90-120 min/session, offered 2-3 times/week after school. Non-peer led with HIV information, coping, skills training, access to health care, social support, private counseling. 20-session intervention, 90-120 min. each, 10 youth per session. No control group. | Follow-up at 3, 6, & 12 months. Protected anal intercourse (PAI) increased from 60% to 78%. Less risk in past, no commercial sex work, and attending more sessions = more risk reduction. Of racial/ethnic groups African-Am reduced risk most (PAI increased from 36% to 84%). |

| Valdiseri, R.O., Lyter, D.W., et al. (1989). AIDS Prevention in homosexual and bisexual men: results of a randomized trial evaluating two risk-reduction interventions. *AIDS* 3:21-6. | | |
|---|---|---|
| Caucasian | 584 participants randomly assigned to 2 peer-led interventions: 1) a 1-session, 60-90 min small group lecture on HIV transmission, clinical manifestations of HIV infection, condom use, and meaning of HIV antibody test results or 2) small group lecture plus 50 min. skills training on safer sex negotiation. | Condom use during insertive AI higher among skills training (36% at baseline, 69% at 6-month follow-up, and 80% at 12 months than among single lecture group (44% at baseline, 43% at 6 months and 55% at 12 months). No difference in condom use during receptive AI at both follow-ups. |

# Effective Interventions for Men Who Have Sex With Men

| **Group-Level (cont.)** | | |
|---|---|---|
| Huerts, M. (2001) Hermonas de Luna y Sol: The Building of an Empowered Community. *First Annual CAPS Conference*, April 2001. | | |
| Latino | Intervention for Latino MSM engaging in UAI, mostly self-identified as gay or bisexual and born abroad. Program includes: 1) six-week discussion workshop with HIV prevention curriculum promoting social connectedness, critical thinking and exploration of factors and barriers that compete with safer sex intentions; 2) weekly discussion/support group for graduates of main program; and 3) individual, client – centered risk-reduction counseling to address individual prevention needs. Ethnically, culturally, and linguistically appropriate. Sessions addressed main issues Latino gay men face, exploring strategies for survival, sharing the role sex has in their lives, emotional challenges, exploring AIDS impact on their lives, and exploring diversity. | Preliminary evaluation data show increased condom use for anal sex, self-esteem, and social networks. |

| Peterson, J.L., Coates, T.L., et al. (1992). High-risk sexual behavior and condom use among gay and bisexual African-American men. *American Journal of Public Health* 82: 1490-4. | | |
|---|---|---|
| POC (African-Am) | 318 African-American MSM in SF from 1989-1991. Randomly assigned to 1- session, 3-session, or wait-list control group. 3-session non-peer mediated counseling consisted of 3-hour group sessions one week apart with 10 participants in each group. Components: self-identity and development of social support, AIDS risk education, assertiveness training, and behavioral commitment. Attendance problems: 53% of men in 3-session attended at least 1 session (at least 12% attend one session, 16% attended at least two sessions, and 25% attended all three sessions). 45% of men assigned to the 1-session group, actually attended the session. | Participants in 3-session intervention showed significant reduction in UAI at both 12 and 18-month follow-ups and were more likely to test for HIV. Reduction from baseline was 45% to 20%. Risk behavior in control group remained constant and declined only slightly in 1-session group.<br>Comment: In spite of blocked randomization, control group was much less risky at baseline. |

# Effective Interventions for Men Who Have Sex With Men

| **Group-Level (cont.)** | | |
|---|---|---|
| Rosser, S.B.R., Bockting, W.O., Rugg, D.L., et al. (2002). A Randomized Controlled Intervention Trial of a Sexual Health Approach to Long-Term HIV Risk Reduction for Men Who Have Sex with Men: Effects of the Intervention on Unsafe Sexual Behavior. *AIDS Education and Prevention* 14, Supplement A: 59-71. | | |
| | Sexual Health approach ("an approach to sexuality founded in accurate knowledge, personal awareness and self-acceptance and in which one's behavior, values, and emotions are congruent and integrated into one's personality and self-definition"). N=422 Midwestern MSM. Random assignment to either 1) 2-day comprehensive human sexuality seminar designed to contextually address long-term risk factors and cofactors or 2) control group who watched 3 hours of HIV prevention videos. (Only 17% attrition at 12-month follow-up, but ultimately only 40% completed all questions necessary for inclusion in analysis. Prevalence of unsafe sex at baseline only 14.2%) | Risk behaviors in preceding 3 months measured at baseline, 3 months, and 12 months. Measured any UAI outside of long-term seroconcordant relationship. At 12 months, control group reported 29% decrease in use of condoms during anal intercourse; intervention group reported 8% increase in condom use. Both groups appear to be making contextual decisions about risk (engaging in UAI when they have estimated the risk is low). |

| **Community-Level** | | |
|---|---|---|
| Kelly, J.A., St. Lawrence, J.S., et al. (1992). Community AIDS/HIV risk reduction: The effects of endorsements by popular people in three cities. *American Journal of Public Health* 82: 1483-9. | | |
| *"Popular Opinion Leader"* | Trained 924 opinion leaders (POLs) in an intervention city. Lagged implementation into 2 other cities. Surveyed bar patrons in all 3 cities at same time points. POLs received 4 sessions, 90 minutes each, covered HIV education and communication strategies. POLs then agreed to have 14 peer conversations about AIDS risk reduction (personal endorsement). Study conducted from 1989-1991.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064 | Significant reductions in the mean % of men who practiced UAI in Biloxi (24% at 3 month follow-up) and Monroe (21%) but the 15% decline observed in Hattiesburg insignificant. Also, significant change in the % of men with multiple sexual partners. At 3-year follow-up, reductions in UAI and increases in condom use continued to occur (St Lawrence JS, Brasfield, T.L., Diaz, Y.E., et al. (1994) Three-year follow-up of an HIV risk-reduction intervention that used popular peers [letter]. *American Journal of Public Health* 84: 2027-2028.). |

# Effective Interventions for Men Who Have Sex With Men

| **Community-Level (cont.)** | | |
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| AIDS Community Demonstration Projects Research Group (1999). Community-Level HIV Intervention in 5 cities: Final Outcome Data From the CDC AIDS Community Demonstration Projects. *American Journal of Public Health*: 89, 336-345. | | |
| Non-Gay-Identified<br><br>*"Community Promise"* | *Community Promise* (Peers Reaching Out and Modeling Intervention Strategies) is included on CDC's Replicating Effective Programs web page (http://www.cdc.gov/hiv/projects/rep/promise.htm). Populations that intervention used with: injection drug users, their female sex partners, sex workers, non-gay identified men who have sex with men, high risk youth and residents in areas with high rates of sexually transmitted disease. Persons from the at-risk communities are recruited and trained to be community advocates and to distribute role model stories and risk reduction supplies on the streets of their communities. Role model stories are personal accounts from individuals in the target population explaining how and why they took steps to practice HIV risk-reduction behaviors and the positive effects the choice has had on their lives. The messages in the role model stories are reinforced by interpersonal communication with the community advocates. Each week, community advocates distribute stories and supplies to 10 to 20 of their peers.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064 | Communities where Community PROMISE was conducted showed increased consistent condom use by community members with their main and non-main partners and increased condom carrying among members of the communities. |

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| Kelly, J.A., Winett, R.A., et al. (1993). Social diffusion models can produce population-level HIV risk-behavior reduction: field trial results and mechanisms underlying change. *IX International Conference on AIDS/IV STD World Conference* Berlin, Germany (Abstract POC23-3167). | | |
| | For a 5-week period, trained opinion leader in four experimental cities engaged in peer conversations about the benefits and appropriateness of risk behavior and change, strategies to implement change, and risk misconception at local gay bars. Four matched cities were selected as control. 701 participants. (See also Kelly JA, Murphy DA, Sikkema KJ, et al. (1997) Community HIV Prevention Research Collaborative: randomized, controlled community-level intervention for sexual risk behavior among homosexual men in US cities. (*Lancet* 350: 1500-1505.) | The community intervention led to decreased proportions of men who engaged in any UAI (from 33% at baseline to 25% at 9 month follow-up), unprotected insertive anal sex (27% to 17%), and unprotected receptive anal sex (22% to 16%) in the experimental relative to control cities (little change observed at the follow-up). |

# Effective Interventions for Men Who Have Sex With Men

| **Community-Level (cont.)** | | |
|---|---|---|
| Kegeles, S.M., Hays, R.B., et al. (1996) The Mpowerment Project: A community-level HIV prevention intervention for young gay and bisexual men. *American Journal of Public Health* 86: 1129-36. | | |
| Young Gay men (18-29)<br><br>*"Mpowerment Project"* | Peer-led program with three components: outreach (formal and informal), small group, and publicity campaign. Program run by Core Group and community advisory board of "elders". Groups were one-time 3-hour small group meetings (8-10 people), which focused on safer sex and HIV information, communication and interpersonal skills. Independently from the prevention program, a cohort of young gay men (n=300) surveyed in intervention and comparison community. Wait-list control design.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064 | Reduction in all UAI from 41% to 30%, from 20.2% to 11.2% with non-primary partners and from 58.9% to 44.7% with boyfriends. No significant changes in comparison community. Reductions sustained 1 year later with non-primary partners, mixed results for sex with boyfriends (Kegeles SM, Hays RB, Pollack LM, Coates TJ (1999) Mobilizing young gay and bisexual men for HIV prevention: a two-community study. *AIDS* 13: 1753-1762.). 87% of intervention community respondents had heard of project and 77% had experienced at least two project activities. High risk-taking men less likely to attend small groups, volunteer for outreach, or be Core Group member. Cost-effectiveness data: Kahn JG, Kegeles SM, Hays R, Beltzer N (2001). Cost-effectiveness of the Mpowerment Project, a community-level intervention for young gay men. *JAIDS* 27(5): 482-91. |

| **Street and Community Outreach** | | |
|---|---|---|
| Hospers, H.J., Debets, W,, Ross, M.W., and Kok, G. (1999). Evaluation of an HIV prevention intervention for men who have sex with men at cruising areas in the Netherlands. *Aids and Behavior* 3: 359-366. | | |
| | Program in the Netherlands that trains volunteers to go into cruising areas (CA) to talk with CA visitors about importance of safer sex. Give risk information, explain why safer sex important, brochure, condom and lube. No conversations with visitors that didn't want to talk. | Post-intervention survey of people who said had at least one conversation with a volunteer (conversation group, n=172) and those who hadn't been approached but would have had a conversation (no conversation control group, n=190). Conversation group had significantly higher condom use for insertive and receptive AI. MSM increased condom use more than MSMW. |

# Effective Interventions for Men Who Have Sex With Men

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| **HIV Antibody Counseling & Testing -** CDC Revised Guidance for HIV Counseling, Testing, and Referral. MMWR 2001, 50 (RR-19); 1-58 (http://www.cdc.gov/mmwr/pdf/rr/rr5019.pdf) | | |
| Higgins, D.L., Galavotti, C., et al. (1991) Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *Journal of American Medical Association* 266(17): 2419-2429. | | |
| | Overall review of 50 C&T studies. 17 of these look at effect of C&T on behavior change (condom use, reduction of sexual partners) of MSM. | For MSM: All studies reported risk reduction among tested and untested men, a few reported greater decreases in seropositive than seronegative. States that it is hard to draw firm conclusions about impact of C&T on MSM risk behavior. |

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|---|---|---|
| Higginbotham, S., Holmes, R., Stone, H., Beil, J., Datu, Costa, S., G.B., Paul, S., (2000) Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis--- Alabama, New Jersey, and Tennessee, 1997--1998. *MMWR June 16, 2000/*49(23); 512-515 | | |
| | To examine risk behaviors (e.g., condom use and number of sex partners) after HIV diagnosis, CDC analyzed data on HIV Testing history and sexual behavior of persons who may have recently acquired HIV infection as part of a CDC sponsored study in Alabama, New Jersey, and Tennessee. For purpose of the study, criteria for recent HIV infection included persons with diagnosed and reported HIV infection with CD4 T-lymphocyte counts >700 cells/ul or percentage>36, documented HIV seroconversion within 18 months of confirmed HIV infection diagnosis, or persons aged 13-24 years when diagnosed. During January 1997 through September 1998, 615 persons with HIV infection diagnosed and reported met the criteria for the study. These persons represented 15% of all persons reported with HIV in the three states. Prior to diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males 25% reported never using a condom, 69% reported sometimes using a condom, and 6% reported always using condoms. | Of the 543 persons eligible after follow-up, 180 persons completed the interview within 12 months of the self-reported date learning they were HIV infected (median: 6 months). Among those, 99 (55%) were female; 96 (53%) were <25 years old; and 105 were non-Hispanic blacks, 49 were non-Hispanic white, 24 were Hispanic, and two self reported as "other". 162 (90%) responded that they had changed their behavior since learning of their HIV infection. After diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males, 30% reported not having sex, 6% reported never using a condom, 11% reported sometimes using a condom, and 47% reported always using condoms. The number of sexual partners for the males and females decreased as well. |

# Effective Interventions for Men Who Have Sex With Men

| **Drug Treatment** | | |
|---|---|---|
| Shoptaw, S., Reback, C.J., Frosch, D.L., Rawson, R.A. (1998). Stimulant Abuse Treatment as HIV Prevention. *Journal of Addictive Diseases* 17(4): 19-32. | | |
| Non-IDU drug users | Individuals who use illicit stimulants, primarily cocaine and methamphetamine, engage in substantial amounts of HIV–related sexual risk behaviors when under the influence. This paper presents the idea that reductions in stimulant use consequent to drug treatment makes stimulant drug treatment an important HIV prevention tool for this high–risk population. | Presents data to describe HIV–related sexual risks reported by out–of–treatment methamphetamine users and by cocaine and methamphetamine abusers at treatment entry and six months post treatment entry. Overall, findings demonstrate that following initiation of a treatment episode, stimulant abusers demonstrate significant reductions in HIV–related sexual behaviors, primarily by reducing the number of sexual partners. |

| Stall, R., Paul, J.P., Barrett, D.C., Crosby, G.M., Bein, E. (1999). An Outcome Evaluation to Measure Changes in Sexual Risk-Taking among Gay Men Undergoing Substance Use Disorder Treatment. *Journal of Studies on Alcohol* 60: 837-845. | | |
|---|---|---|
| Non-IDU drug users | Men recruited as they entered substance use treatment. Five waves of data collection, each wave measuring the previous 90 days. 82 men assigned to the experimental condition (treatment plus a safe sex intervention); 65 were assigned to the regular substance use treatment. CONCLUSIONS: (1) substantial HIV risk reductions can occur after initiation of treatment for substance use; (2) risk reductions begin soon after treatment begins; (3) lapses to unsafe sex are common; (4) continued UAI most likely among those men who are riskier at intake, who continue to be more sexually active and who combine substance use and sexual behavior; (5) AIDS prevention activities conducted at treatment agencies cannot reach all high-risk substance-using gay men. | Although levels of risk within each wave were never significantly different between the two treatment groups, reductions in unprotected anal intercourse (UAI) with a nonmonogamous partner for both groups from the baseline Wave-1 levels were uniformly significant. Such high-risk sex in the year-long follow-up period was correlated with UAI reported at intake, enjoyment of UAI, relative youth, heavier concurrent use of alcohol or amphetamines and greater numbers of sexual partners. |

# Effective Interventions for Men Who Have Sex With Men

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| **CDC Partner Notification Guidance** - www.cdc.gov/hiv/partners/interim/partnercounsel.htm<br>**Procedural Guidance Intervention –** http://www2a.cdc.gov/hivpra/documents/Attachments/cbofinal/Pages from CBOProcedures_15Dec03_FinalDraft_10.pdf | | |
| Partner Counseling and Referral Services to Identified Persons with Undiagnosed HIV---North Carolina. MMWR December 5, 2003/52 (48); 1181-1184 | | |
| | In 1989, North Carolina Department of Health and Human Services began offering PCRS to clients who tested positive in confidential and anonymous testing venues. HIV infection became reportable in 1990 and anonymous testing was discontinued in 1997. A trained disease intervention specialist (DIS) completed six important steps. All notified partners received risk reduction counseling and appropriate referrals. | Data collected from 2001 revealed a total of 1,603 persons were newly reported to have HIV infections. DIS were assigned to conduct PCRS with 1,580 (99%) index clients, 1,378 (87%) were located and PCRS identified 1,532 sex or needle sharing partners. 1,359 partners were located and notified of their possible exposure to HIV. After PCRS, from those who not previously testing positive for HIV, 108 newly tested partners were diagnosed HIV positive. |

**No reviews on Mass & Other Media, Social Marketing, Hotlines, Clearinghouse, or Partner Notification**

# Effective Interventions for Injection Drug Users
## Literature Summary

### Methadone Treatment

Many articles support the effectiveness of methadone treatment as an HIV prevention intervention for heroin users. The studies show that methadone treatment reduces needle use, sharing and number of sex partners. Rather than summarizing each article, this document provides several citations to help users begin to access the literature on this topic.

Gibson, D.R., Flynn, N.M/, and McCarthy, J.J. (1999). Effectiveness of methadone treatment in reducing HIV risk behavior and HIV seroconversion among injecting drug users. *AIDS* 13: 1807-1818.

Hubbard, R.L, Marsden, M.E., Rachel, J.V., et al. (1989). Drug Abuse Treatment: A National Study of Effectiveness (Chapel Hill, NC: University of North Carolina Press, 1989), cited in The Effectiveness of AIDS Prevention Efforts (Washington DC: Office of Technology Assessment).

Langendam, M.W., van Brussel, G.H.A., Coutinho, R.A., et al. (1999). Methadone maintenance treatment modalities in relation to incidence of HIV: results of the Amsterdam cohort study. *AIDS* 13: 1711-1716.

Rhoades, H.M., Creson, D., Elk, R., et al. (1998). Retention, HIV risk, and illicit drug use during treatment: methadone dose and visit frequency. *American Journal of Public Health* 88: 34-39.

# Effective Interventions for Injection Drug Users

## Syringe Exchange

Many articles support the effectiveness of syringe exchange as an HIV prevention intervention for injection drug users. The studies show that syringe exchange programs reduce sharing and increase referrals to drug treatment programs, without increasing injection drug use. Rather than summarizing each article, this document provides several citations to help users begin to access the literature on this topic.

Ashery, R.S., Davis, H., Davis, W.H., et al. (1993). Entry into treatment of IDUs based on the association of outreach workers with treatment programs. Handbook on Risk of AIDS**,** Brown, B.S. and Beschner, G.M. (eds.) (Westport, CT: Greenwood Press), cited in The Effectiveness of AIDS Prevention Efforts (Washington DC: Office of Technology Assessment).

Bluthenthal, R.N., Kral, A.H., Gee, L., et al. (2000). The effect of syringe exchange use on high-risk injection drug users: a cohort study. *AIDS* 14: 605-611.

Hagan, H., Des Jarlais, D.C., Friedman, S.R., et al. (1995). Reduced risk of Hepatitis B and Hepatitis C among injecting drug users participating in the Tacoma Syringe Exchange Program. *American Journal of Public Health* 85: 1531-1537.

O'Brien, M., Murray, J.R., Rahemian, A., et al. (1994). Three topics from the Chicago Needle Exchange Cohort Study: seroconversion; the behavior of HIV-positive NX users; and the need for additional prevention around non-needle injection risks. *Annual North American Syringe Exchange Conference***,** Santa Cruz, CA, cited in The Effectiveness of AIDS Prevention Efforts (Washington DC: Office of Technology Assessment).

O'Keefe, E., Kaplan, E. and Khoshnood, K., (1991). *Preliminary Report: City of New Haven Needle Exchange Program* (New Haven, CT: New Haven Health Department), cited in The Effectiveness of AIDS Prevention Efforts (Washington DC: Office of Technology Assessment).

Oliver, K., Maynard, H., Friedman, S.R., et al. (1994). Behavioral and community impact of the Portland Syringe Exchange Program. *Proceedings of the Workshop on Needle Exchange and Bleach Distribution Programs* (Washington, DC: National Academy Press), cited in The Effectiveness of AIDS Prevention Efforts (Washington DC: Office of Technology Assessment).

# Effective Interventions for Injection Drug Users

| Individual-Level | | |
|---|---|---|
| Stephens, R.C., Feucht, T.E., et al. (1993) Effects of an Intervention Program on AIDS-Related Drug and Needle Behavior Among Intravenous Drug Users. *American Journal of Public Health* 81(5): 568-571. | | |
| POC (African-American Male) | 322 (mostly street addicts not in tx) participated in 1:1 counseling delivered by a professionally trained health educator and lasted 45-60 minutes. Session provided basic information on HIV transmission using a segment of a film; discussed sexual risk reduction and condom use; covered ways to reduce risk due to injection drug use and ended with information on HIV testing. | Pre-post results compared baseline to 3-month follow-up interview. Percent reporting injecting decreased from 92 to 71, sharing decreased from 67 to 24. Didn't ask questions about sexual risks. |

| Prevention Case Management |
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| The CDC has endorsed Prevention Case Management (PCM) as an effective intervention to reach HIV positive and/or very high-risk HIV negative persons. PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. PCM provides client-centered, multiple-session HIV risk reduction counseling while using the service brokerage of traditional case management to address competing needs that may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use, mental health, adherence issues, social and cultural factors, and physical health problems. While PCM has yet to be rigorously evaluated, intensive case management interventions for clients with multiple, complex problems have been shown to be effective in other health fields. **CDC PCM Guidance September 1997** http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm. **Literature Review** – www.cdc.gov/hiv/pubs/pcml/pcml-doc.htm. **Acronyms** – www.cdc.gov/hiv/pubs/pcmg/pcmg-acr.htm |

| Group-Level | | |
|---|---|---|
| Cottler, L.B., Compton, W.M., et al. (1998) Peer-Delivered Intervention Reduces HIV Risk Behaviors among Out-of-Treatment Drug Abusers. *Public Health Report* 113(1): 31-41 | | |
| POC/ African -Am | St. Louis Program (Each OneTeach One). N=725, 61% male, 93% African-American. A peer role model for out-of-tx crack cocaine users and IDU. Role Models conducted outreach to reach persons on the street spending 5 to 15 minutes contact with users, then random assignment to standard or enhanced intervention. All participants in two sessions of drug and HIV info and C&T, then EI participants randomly selected to attend four 2-hour peer-led intervention groups on drug awareness, stress management, AIDS, risk reduction for sexual behavior. | 3-month follow-up. Over 80% of the sample (both groups) maintained their crack cocaine use at low-level or reduced their use. Enhanced group more likely to reduce risk. Condom use in both groups decreased. Men in enhanced intervention more likely to reduce crack use than standard intervention men. No difference between women in two groups. |

# Effective Interventions for Injection Drug Users

| **Group Level (cont.)** | | |
|---|---|---|
| Deren, S, Tortu, S., et al. (1993) An AIDS Risk Reduction Project with Inner-city Women, *Women and AIDS: Psychological Perspectives.* London: Sage. | | |
| POC/ Women (African-Am/ Latino) | Women were randomly assigned to two groups.<br>Group 1: a single group session providing AIDS education and testing/risk reduction referral information.<br>Group 2: three group session, covering the above plus condom use/needle-cleaning and negotiation skills. | Women in both interventions showed significant decrease in average monthly number of unprotected sex acts (37 to 19) and number of partners (31 to 15) in the last 6 months. Increased percent condoms use with main partner (18% to 43%) and with multiple partners (43% to 64%) at 6-month follow-up. |

| Des Jarlais, C.C., Casriel, C., et al. (1992) AIDS and the Transition to Illicit Drug Injection – Results of a Randomized Trial Prevention Program. *British Journal of Addiction* 87(3): 493-498. | | |
|---|---|---|
| | Study to see if teaching safer injecting practices would cause injecting to increase among drug sniffers. 104 NYC HIV negative heroin users who were using intranasaly (sniffing) as their primary route of heroin use and who had injected no more than 60 times in the previous two years. Trained peer-mediator conducted four 60-90 minute group sessions over a two-week period, which included AIDS 101, safer injection, sexual behavior, and drug abuse treatment programs. Controls filled out surveys that were in-depth interviews. | Significant lower level of injection at follow-up (average follow-up period = 9 months). Did not prevent all drug injection. 15% assigned to the intervention injected during the follow-up period, compared with 33% of those assigned to the control group. There however was no evidence that the intervention was effect at improving safer sex. |

| El-Bassel, N., Schilling, R.F. (1992) 15- Month Follow-up of Women Methadone Patients Taught Skills to reduce Heterosexual HIV Transmission. *Public Health Reports* 107(5): 500-4. | | |
|---|---|---|
| IDU/ POC (African-Am/ Hispanic) | 15-month follow-up of study summarized above (Schilling, R.F., EL-Bassel, N., et al. (1991) Building Skills of Recovering Women Drug Users to Reduce Heterosexual AIDS Transmission. *Public Health Reports* 106(3): 297-304). | Compared to the information-only group, women in the skills-building group showed an increase in frequency of condom use at 15-month follow-up. The groups did not differ significantly in number of sex partners. |

| Malow, R.E., West, J.A., et al. (1994) Outcome of Psychoeducation of HIV risk reduction. *AIDS Education and Prevention* 6(2): 113-125. | | |
|---|---|---|
| POC/ Drug use (African American cocaine users) | 152 African American males at in-patient tx program participated in group-level sessions. Non-peer led, held for 2 hours over 3 consecutive days, 6-8 people. Sessions included HIV knowledge/ risk, demonstrated cleaning works; condom use, condom negotiating, and skills-building exercises; review and discussion of HIV testing procedures. | 47.5% of intervention group participants reported having more than one partner at three-month follow-up compared to 76% at the baseline in the comparison group. The change from 76% at baseline to 59% at the follow was considered to be not statistically significant. Sexual risk taking in those receiving the intervention was reduced from 75% (pre intervention) to 32% (follow-up). |

# Effective Interventions for Injection Drug Users

| **Group-Level (cont.)** | | |
|---|---|---|
| McCusker, J., Stoodard, A.M., et al. (1992) AIDS Education for Drug Abusers: Evaluation of Short-term Effectiveness. *American Journal of Public Health* 82(4): 533-540. | | |
| In drug treatment | Massachusetts. 567 clients in a 21-day inpatient drug detoxification program. 67% male, 81% white. Blocked randomization. Group 1: standard AIDS education program typically provided in treatment settings, consisted of two 1-hour group sessions given early or late in tx involving video, lectures, homework, discussion, and demonstrations of condom use and of cleaning drug equipment. Group 2: enhanced intervention, six 1-hour group sessions and a 30 min individual health education consultation that focused on personal susceptibility, situational analysis and skills-building. | Authors disappointed in results. Reduction in risky drug use reported by all groups. Only significant result: enhanced group reported significantly greater reduction in injection frequency than did group 1. |

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|---|---|---|
| Schilling, R.F., EL-Bassel, N., et al. (1991) Building Skills of Recovering Women Drug Users to Reduce Heterosexual AIDS Transmission. *Public Health Reports* 106(3): 297-304. | | |
| Women/ POC | 91 African-American and Hispanic women enrolled for at least 3 months in five clinics in large methadone maintenance program in NYC. Non-peer led skills-building groups held five 2-hour sessions offered to groups of 9-10. Topics included: HIV 101; identification of high-risk sexual practices; discussion of barriers to adopting safer sex practices; discussion of negative associations with condoms; condom use skills; role-played negotiation of condom use; assertiveness; problem solving; and communication skills involving safer sex scenarios. Comparison group received one session of AIDS information routinely provided by the clinic. | The skill-building intervention group showed statistically significant higher use of condoms than those in the control group at follow-up. Participants also more comfortable taking and carrying condoms, talking about safer sex with partners, had more favorable attitudes toward condoms. No drug use differences between groups.<br>Comment: Initial follow-up was 2-week post. |

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|---|---|---|
| Harris, R., Kavanagh. S., Bausell, H. (1998) An intervention for changing high-risk HIV behaviors of African-American, drug dependent women. *12th World AIDS Conference, Geneva 1998* [Abstract No. 13402]. | | |
| POC/ Women (African-Am) | 204 methadone-dependent, African-American women randomized into experimental and control groups. Experimental group participated in peer counseling and leadership training program over an 8-week period, followed by 8 weeks of reinforcement. Program designed to reduced sexual risk behavior, increase self-esteem, decrease depressive affect, and increase AIDS knowledge. | Compared to controls, experimental group reported significant increase in numbers of safer sexual behaviors, showed decreases in depression, and reported engaging in more AIDS-related, community-based communication activities. |

# Effective Interventions for Injection Drug Users

| **Community-Level** | | |
|---|---|---|
| Jamner, M.S., Wolitski, R.J., et al. (1997) Impact of a Longitudinal Community HIV Intervention Targeting Injecting Drug Users Stage of Change for Condom and Bleach Use. *American Journal of Health Promotion* 12(1): 15-24. | | |
| General | AIDS Community Demonstration Project in Long Beach California. 3081 IDU who were sexually active in the past 30 days or who had shared injection equipment in the past 60 days. Peer volunteers distributed fliers featuring role-model stories targeted to the population's stage of change. Fliers were packaged with bleach kits, condoms, or both. The intervention was designed to influence behavior through the dissemination of information, the development of behavioral skills and the positive reinforcement of progress toward the consistent use of condoms and bleach. (Transtheoretical model of behavior change) | Repeated cross-sectional sampling with matched intervention and comparison communities. Compared with injecting drug users in the comparison area, IDUs in the intervention area showed a significant increase in condom use with non-main partners. Subjects with recent project exposure had higher stage-of-change scores for using condoms with main and other partners and for cleaning injection equipment with bleach. |

| Rietmeijer, C.A., Kane, M.S., et al. (1996) Increasing the Use of Bleach and Condoms Among Injecting Drug Users in Denver: Outcomes of a Targeted, Community-level HIV Prevention Program. *AIDS* 10(3): 291-298. | | |
|---|---|---|
| General | The AIDS Community Demonstration Project was conducted in Denver (890 participants) and the comparison site was Long Beach (1107 participants). Of the total IDUs interviewed (N=1997), in Denver 89% were male, 31% Hispanic, and 34% black. In Long Beach, 75% were male, 21% Hispanic, and 51% black. Over a 2.5-year period, volunteers discussed and distributed intervention kits with small-media behavior intervention materials, role model stories, bleach kits and condoms to the 890 high-risk IDUs in Denver on a monthly basis. Workers received training on basic HIV/AIDS education, role-playing interactions, methods of street approach and non-threatening conversation, and methods of dealing with individuals who refuse materials. | Proportion reporting consistent bleach use to clean needles increased significantly from baseline (20%) to early (16%) to full implementation (29%) in the intervention city; but decreased from 22% at baseline to 12% at early and full implementation in the comparison city. Condom use during vaginal intercourse with occasional partner increased significantly from 2% at baseline to 7% at early implementation and to 24% at full implementation of the invention city and decreased from 12% to 10% in comparison city. No change on condom use with steady partner. |

# Effective Interventions for Injection Drug Users

| Street and Community Outreach | | |
|---|---|---|
| Coyle, S.L., Needle, R.H., et al. (1998) Outreach-Based HIV Prevention for Injecting Drug Users: A Review of Published Outreach Data. *Public Health Report* 113(1): 19-30. | | |
| General | Review of 36 published studies of outreach-based HIV risk reduction interventions for out-of-tx IDUs. Reports intervention effect on HIV related behaviors or HIV seroincidence. Most from National AIDS Demonstration Research (NADR) or Cooperative Agreement for AIDS Community-based Outreach/Intervention Research Program—both models used a standard outreach with C&T and enhanced outreach with follow-up of counseling, role-playing, etc.). 2/3 of interventions were street-based outreach followed by office-based HIV C&T. | Most results are pre-post, no controls. Consistency of results across studies. IDUs regularly reported follow-up reductions in 5 major risk behaviors: stopping injecting, reducing frequency of injecting, reducing reuse of syringes, reducing reuse of other equipment, reducing crack use. Studies also show significant effects in 3 protective behaviors: more frequent needle disinfecting, entry into drug tx, and increases in condom use. |

| Latkin, C.A., (1998) Outreach in natural settings: the use of peer leaders for HIV prevention among injecting drug users' networks. *Public Health Report* 113 (Suppl 1): 151-9. | | |
|---|---|---|
| POC (African-Am) | Baltimore, Maryland. 36 peer leaders trained to promote prevention among contacts within and beyond sex and drug networks. Peer leaders participated in 10-session training groups were administered pretest and post-test surveys. Survey data also collected from 78 of the leaders' risk network members. Peer leaders had 2165 HIV prevention interactions, of which 84% were with active drug users. | Peer leaders reported a significant increase in condom use and cleaning used needles with bleach. The leaders' risk network members, compared with controls, were significantly more likely to report greater needle hygiene. |

# Effective Interventions for Injection Drug Users

| **Street and Community Outreach (cont.)** | | |
|---|---|---|
| NADR (National AIDS Demonstration Research) Program and CA (Cooperative Agreement) Program for HIV/AIDS Community-based Outreach/Intervention Research). | | |
| Out-of-treatment injection drug users and the non-injecting female sex partners of male IDUs | **NADR**: large study carried out from 1987 to 1991 in 29 sites across the US. Used indigenous outreach workers to initiate risk-reduction activities on the streets and in other settings where IDUs tend to congregate. Basic risk-reduction activities usually involved face-to-face communication; the provision of literature on HIV/AIDS transmission, prevention and treatment; and the distribution of risk reduction materials. Outreach workers also referred drug users to services, including drug treatment services as well as HIV/AIDS treatment. Outreach was generally followed with additional, structured activities, such as confidential HIV testing and counseling and individual risk assessments.<br><br>**CA**: implemented in 23 U.S. sites from 1990 to 1999. Used elements of the NADR program plus clients assigned to basic or "enhanced" intervention services, with basic services held consistent across sites. Outreach activities were similar to those in the NADR program, but were defined more uniformly. The basic intervention entailed community-based outreach as a prelude to two education and counseling sessions, organized around optional HIV testing and counseling to help drug users learn about their serostatus and the behavior changes needed to reduce transmission risks.<br><br>NIDA (National Institute of Drug Abuse) Community-Based Outreach Model: A Manuel to Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users, NIH, Publication Number 00-4812, printed September 2000 165.112.78.61/CBOM/Index.html | Study findings indicate that the outreach-based interventions designed and tested in the NADR and CA programs were effective in reaching at-risk individuals and enabling them to reduce risk behaviors and, consequently, their risk of acquiring HIV/AIDS. Community-based outreach was found to be an effective approach for reaching out-of-treatment drug users, providing materials to support HIV risk reduction, facilitating drug treatment entry and retention, providing referrals for HIV testing and counseling, and promoting HIV risk reduction. The consistency of results is evidence that a strategy of community-based outreach, counseling, and education interventions promoted beneficial drug- and sex-risk behavior changes. |

# Effective Interventions for Injection Drug Users

| Street and Community Outreach (cont.) | | |
|---|---|---|
| Siegal, H.A., Falck, R.S., et al. (1995) Reducing HIV Needle Risk Behaviors Among Injection-Drug Users in the Midwest: An Evaluation of the Efficacy of Standard and Enhanced Interventions. *AIDS Education and Prevention* 7(4): 308-319. | | |
| POC (African Am) | NADR site. 907 participants (74% male, 75% African-Am) assigned to one of two types of standard or enhanced intervention. Standard: a one-hour session (in the field office) which the counselor-educator provided details on HIV disease and modes of transmission and an instructional session which was followed by a videotape of role plays illustrating proper condom use and needle cleaning. Bleach and condoms provided. Enhanced: added to the standard intervention three one-to two-hour sessions on the pathology of HIV disease, drug addiction and safer sex. These were delivered over a one-month period in-group sessions of 3-5 people. All participants received voluntary and confidential HIV counseling/testing as well as knowledge of negative results. | Follow-ups 5 to 9 months after baseline. Both interventions appeared to improve needle practices. The enhanced intervention showed more effectiveness in helping those with unsafe practices to become more safe, but did not appear to be more effective at helping those practicing safer needle practices maintain those practices. In multivariate analysis, subjects in enhanced more likely to change from unsafe to safe needle use. Regardless of intervention track, daily injectors less likely to adopt safer injecting practices than weekly or occasional injectors. |

| | | |
|---|---|---|
| Wiebel, W.W., Jimenez, A., Johnson, W., et al. (1996) Risk behavior and HIV seroincidence among out-of-treatment injection drug users: A four-year prospective study. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 12: 282-289. | | |
| POC | NADR site. Monitored trends in HIV risk behaviors and seroconversion among out-of-treatment IDUs receiving street-based outreach in Chicago. Began 1988, followed 641 HIV seronegative IDUs for 4 years. Intervention guided by Indigenous Leader Outreach Model. Ex-addicts delivered HIV prevention services targeting IDU social networks in community settings. Collected baseline and 6 waves of follow-up interview data. Subjects came from 3 low-income neighborhoods: African-Am, ethnically mixed, and Puerto Rican. | Observed HIV incidence decreased, from 8.4 to 2.4 per 100 person-years. Prevalence of drug risk behaviors (sharing needles or equipment without disinfecting) decreased, from 100% to 14%. Sex risk behavior (multiple partners, sex with an IDU, or not always using condoms) decreased, from 71% to 45%. |

# Effective Interventions for Injection Drug Users

| **Intervention Combination** | | |
|---|---|---|
| Kipke, M.D., Edgington, R., et al. (1998) HIV Prevention for Adolescent IDUs at a storefront needle exchange program in Hollywood, CA. *Presented at the 12 The World AIDS Conference, Geneva Switzerland* [Abstract No. 23204]. | | |
| Youth (24 and under) | Needle exchange targeting young IDUs, which contains, art programming, peer-support groups, HIV testing and case management (largest youth NEP in the US). | Over 70% of clients reported no needle sharing in the last 30 days, and young people who used the NEP on a regular basis were less likely to share needles. |

| Nyamathi, A.M., Flaskenis, J., et al. (1994) Evaluation of Two AIDS Education Programs for Impoverished Latina Women. *AIDS Education and Prevention* 6(4): 296-309. | | |
|---|---|---|
| POC Women drug using/ homeless | The purpose was to evaluate and contrast the effectiveness of two culturally sensitive AIDS education programs. 131 women participated in the traditional program where they received one hour of AIDS education and community resource information. 82 women participated in a specialized program where the information was extended to include reinforcement of risk skills and enhancement of self-esteem and control. | Over the two-week interval, significant improvements were found in both groups for all cognitive and psychological variables, except problem-focused coping. High-risk IV drug use (in those who reported this behavior during the pre test) decreased from 18 to 7 in the traditional group and from 14 to 0 in the specialized group. Likewise, reports of non-IV drug use and sexual activity with multiple partners decreased in both groups.<br>Concern: Very short follow-up. |

| Tross, S., Abdul-Quader, A.S., et al. (1993) Evaluation of a Peer Outreach HIV Prevention Program for Female Partners of Injecting Drug users (IDUs) in New York City. *IX International Conference on AIDS* 9,840. | | |
|---|---|---|
| Women | 658 Female sex partners of IDU residing in a high use housing project. Peer outreach/media distribution of flyers containing risk reduction strategies of actual peer models occurring in 2 randomly selected housing projects. Two non-intervention housing projects provided a comparison sample. | At follow-up, there was no change in condoms use or intention to use condoms in the comparison sample, while the intervention sample showed increased percentage always using condoms (18% to 30%) and decrease percentage never using condoms (46% to 27%). |

| Powers, B., Penn, S., et al. (1990) AIDS Risk Reduction Among Female IVDUs and female sexual partners of IVDUs, 1988-1989. *VI International Conference on AIDS* 6, 421. | | |
|---|---|---|
| Women | Female IDU and female sex partners of IDUs contacted via street outreach were reached individually (4, 724) or in groups (7,829). The intervention was to study the 'early' and 'late' outreach efforts compared to reports of participants in 'safer sex workshops.' Other outreach efforts included provision of condoms and needles, referrals, group and individual counseling and client advocacy. | In early workshops, 15% reported regularly or always using condoms; in later workshops, this increased to 50% (no statistical analysis). |

# Effective Interventions for Injection Drug Users

| **HIV Antibody Counseling & Testing** CDC Revised Guidance for HIV Counseling, Testing, and Referral. MMWR 2001, 50 (RR-19); 1-58 (http://www.cdc.gov/mmwr/pdf/rr/rr5019.pdf) | | |
|---|---|---|
| Higginbotham, S., Holmes, R., Stone, H., Beil, J., Datu, Costa, S., G.B., Paul, S., (2000) Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis--- Alabama, New Jersey, and Tennessee, 1997--1998. *MMWR June 16, 2000*/49(23); 512-515 | | |
| | To examine risk behaviors (e.g., condom use and number of sex partners) after HIV diagnosis, CDC analyzed data on HIV Testing history and sexual behavior of persons who may have recently acquired HIV infection as part of a CDC sponsored study in Alabama, New Jersey, and Tennessee. For purpose of the study, criteria for recent HIV infection included persons with diagnosed and reported HIV infection with CD4 T-lymphocyte counts >700 cells/ul or percentage>36, documented HIV seroconversion within 18 months of confirmed HIV infection diagnosis, or persons aged 13-24 years when diagnosed. During January 1997 through September 1998, 615 persons with HIV infection diagnosed and reported met the criteria for the study. These persons represented 15% of all persons reported with HIV in the three states. Prior to diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males 25% reported never using a condom, 69% reported sometimes using a condom, and 6% reported always using condoms. | Of the 543 persons eligible after follow-up, 180 persons completed the interview within 12 months of the self-reported date learning they were HIV infected (median: 6 months). Among those, 99 (55%) were female; 96 (53%) were <25 years old; and 105 were non-Hispanic blacks, 49 were non-Hispanic white, 24 were Hispanic, and two self reported as "other". 162 (90%) responded that they had changed their behavior since learning of their HIV infection. After diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males, 30% reported not having sex, 6% reported never using a condom, 11% reported sometimes using a condom, and 47% reported always using condoms. The number of sexual partners for the males and females decreased as well. |

| Casadonte, P., Des Jarlais, D. (1990) Psychological and Behavioral Impact among Intravenous Drug Users of learning HIV test results. *The International Journal of Addiction* 25(4): 4 09-426. | | |
|---|---|---|
| POC | 81 drug users tested and informed of HIV positive results. | Giving positive test results were associated in decrease in sex (60%) at a 10 week follow up and more condom and less drug use |

| Higgins, D.L., Galavotti, C., et al. (1991) Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *Journal of American Medical Association* 266(17): 2419-2429. | | |
|---|---|---|
| | A review of 12 studies on the effects of C/T on behavior change (needle use, cleaning of needles and condoms use) of injection drug users (actual study reviews several populations). | From the 12 studies the results were: 50% of the studies showed some increase in needle hygiene; 42% showed decrease in needle or drug use; 25% showed increase in condom usage and, 17% showed decrease sexual partners. |

# Effective Interventions for Injection Drug Users

| **HIV Antibody Counseling and testing (cont.)** | | |
|---|---|---|
| Neaigua, A, Sufian, M., et al. (1990) Effects of Outreach intervention on risk reduction among IDU. *AIDS Education and Prevention* 2(4): 253-271. | | |
| POC | 276 IDU were reached by street educators who were ex-addicts, provided easy referral for HIV testing. No control group. | 4.5-month follow-up. Drug use in last 30 days decreased, times injected decreased; 84% tested – half not return for results. |

| **Partner Notification - CDC Guidance** - www.cdc.gov/hiv/partners/interim/partnercounsel.htm<br>**Procedural Guidance Intervention –** http://www2a.cdc.gov/hivpra/documents/Attachments/cbofinal/Pages from CBOProcedures_15Dec03_FinalDraft_10.pdf | | |
|---|---|---|
| Giesecke, J., Ramstedt, K., Granath, F., Ripa, T., Rado, G., Westrell, M. (1991). Efficacy of partner notification for HIV infection. *Lancet* 338(8775): 1096-1100. | | |
| IDU | Stockholm, 1989-1990. 365 infected patients (91% of those diagnosed in Sweden during the interval) named 564 needle-sharing or sexual partners. | 390 located, 350 with known test results. 50 new seropositives identified. |

| Levy, J.A., Fox, S.E. (1998) The Outreach-assisted Model of Partner Notification with IDUs. *Public Health Report* 113(S-1): 160-9. | | |
|---|---|---|
| General | Chicago. 386 IDU participated. 63 (16%) tested HIV positive; 60 post-test counseled. Randomized to "self-tell" vs. "enhanced" groups. | In "self-tell" group marginal locating information given for at least 142 (50% injecting, 25% sex, 25% both). 82% of IDU in the "enhanced" group wanted the outreach worker to do the partner notification, and 70% of partners notified were done by outreach staff. IDUs wanted assistance in partner notification and were cooperative. |

| Partner Counseling and Referral Services to Identified Persons with Undiagnosed HIV---North Carolina. *MMWR* December 5, 2003/52 (48); 1181-1184 | | |
|---|---|---|
| | In 1989, North Carolina Department of Health and Human Services began offering PCRS to clients who tested positive in confidential and anonymous testing venues. HIV infection became reportable in 1990 and anonymous testing was discontinued in 1997. A trained disease intervention specialist (DIS) completed six important steps. All notified partners received risk reduction counseling and appropriate referrals. | Data collected from 2001 revealed a total of 1,603 persons were newly reported to have HIV infections. DIS were assigned to conduct PCRS with 1,580 (99%) index clients, 1,378 (87%) were located and PCRS identified 1,532 sex or needle sharing partners. 1,359 partners were located and notified of their possible exposure to HIV. After PCRS, from those who not previously testing positive for HIV, 108 newly tested partners were diagnosed HIV positive. |

**No reviews on Mass & Other Media, Social Marketing, Hotlines, and Clearinghouse.**

# Effective Interventions for Heterosexuals

## Literature Summary

| **Group-Level** | | |
|---|---|---|
| Baker, S., et al. (1999) Personal communication | | |
| Women | Choices Project. Women randomly assigned to Relapse Prevention intervention (experiment) or health education and social support intervention (control). Both interventions 16-session, 2-hour weekly groups. | Both groups reduced number of risky sexual acts at 4 months and change is sustained at 12 months. No difference between groups. Both groups also increased and maintained safer sex negotiation skills. |

| Basen-Engquist, K., Coyle, K., et al. (2001) Schoolwide Effects of a Multicomponent HIV, STD, and Pregnancy Prevention Program for High School Students. *Health Education & Behavior* 28 (2): 166-185. | | |
|---|---|---|
| Youth | School-based Safer Choices program, a multicomponent, behavioral-theory-based HIV, STD, and pregnancy prevention program. 20 urban high schools randomized into intervention and control. | At 19 months, decreased frequency of sex without a condom. At 31 months, less sexual intercourse without a condom with fewer partners. Program did not influence prevalence of recent sexual intercourse. Cost-effectiveness study showed that Safer Choices is a cost saving program under a wide range of estimates (Wang, L.Y., et al.).<br>Concern: Setting specific? |

| Cohen, D., Dent, C., et al. (1991) Condom Skills Education and Sexually Transmitted Disease Reinfection. *Journal of Sex Research* 28(1): 139-144. | | |
|---|---|---|
| POC (mostly African-Am) | Los Angeles, California. 192 STD clinic patients most of who were African-Am. Increase familiarity and skill with condoms was a single group session (30 mins) for men and women registered at the STD clinic. The brief condom skills education session was led by a female health educator during regular clinic hours at the STD clinic. | Compared with controls, men and women exposed to the group intervention in the STD clinic waiting room were approximately half as likely to return to the clinic within the next 12 months with a new STD. This was a significant decrease in return rates.<br>Concern: Setting specific? |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Cohen, D., MacKinnon, D.P., et al. (1992) Group Counseling at STD Clinics to Promote Use of Condoms. *Public Health Reports* 107(6): 727-730. | | |
| POC (mostly African-Am) | Los Angeles, California. 426 STD clinic patients most of who were African-Am. Small group format while patients were waiting for their STD clinic appointments. Groups were 10 to 25 people per session. Led by African American female health educator – soap opera-formatted video showing condom use as socially acceptable, a facilitated group discussion on methods of preventing STDs and promoting condom use and role playing, skill-building exercises to enhance condom negotiation with sex partner. | The rate of STD reinfection was significantly lower for men who participated in the intervention than for men who did not participate in the intervention.<br>Concerns: No effect for women. Setting specific? |

| DiClemente, R.J., Wingood, G.M. (1995) A Randomized controlled trial of an HIV sexual risk-reduction intervention for young African-American Women. *Journal of American Medical Association* October 25; 274(16): 1271-1276. | | |
|---|---|---|
| POC/ young women<br><br>"SISTA Project" | Peer mediated 128 sexually active women aged 18-29. Five 2-hour weekly group sessions. Session focused on gender, ethnic prided, knowledge of HIV risk behaviors, prevention strategies, sexual assertiveness, modeling and role playing; correct condom use; norm setting exercises and coping skills, sexual self-control, communication skills, and practicum's.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | At 3-month follow-up. The social skills intervention was effective in increasing consistent condom use. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| El-Bassel, N., Schilling, R.F. (1992) 15- Month Follow-up of Women Methadone Patients Taught Skills to reduce Heterosexual HIV Transmission. *Public Health Reports* 107(5): 500-4 | | |
| IDU/ POC (African-Am/ Hispanic) | 15-month follow-up of study summarized above (Schilling RF, EL-Bassel et al. (1991) Building Skills of Recovering Women Drug Users to Reduce Heterosexual AIDS Transmission. *Public Health Reports* 106(3): 297-304). | Compared to the information-only group, women in the skills-building group showed an increase in frequency of condom use at 15-month follow-up. The groups did not differ significantly in number of sex partners. |

| Eldridge, G.D., St. Lawrence, J.S., Little, C.E., et al. (1997) Evaluation of an HIV risk reduction intervention for women entering inpatient substance abuse treatment. *AIDS* 9: 62-77. | | |
|---|---|---|
| Women/ Drug Use | 117 drug-using women court-ordered into inpatient drug tx. Compared effectiveness of an educational intervention and a behavioral skills training intervention at reducing sexual risk. Both groups reported high rates of sexual risk prior to intervention. | At 2-month follow-up, women in skills training groups showed improvement in communication skills, condom application skill, and condom use. Both groups showed decreased drug use and drug-related high-risk sex activity.<br>Concern: short follow-up |

| Hobfoll, S.E., Jackson, A.P. (1994) Reducing Inner-City Women's AIDS Risk Activities: A Study of Single, Pregnant Women. *Health Psychology* 13(5): 397-403. | | |
|---|---|---|
| Pregnant Women | 206 participants, who were single pregnant women, attended four 90-120 min. group sessions of 2-8 women, taped segments of assertiveness, negotiation, planning, and AIDS prevention skills including role plays, cognitive rehearsal, formulate health action plan. | 6 mo. Follow-up improvement in condom use for vaginal sex, condom and spermicide acquisitions for intervention and not for control.<br>Concern: Applicability to non-pregnant persons. |

| Howard, M., McCabe, J. (1990) Helping teenagers postpone sexual involvement. *Family Planning Perspectives* 22:21-6. | | |
|---|---|---|
| POC/ Youth | Henry W. Grady Memorial hospital, recruited 536 students from their low-income population. Those recruited were less than 16 years old, part of the hospital's family planning program, and were recruited through medical records. Intervention was peer-led 5 sessions, emphasis on postponing sexual involvement, discussing peer pressures, skill practice to resist pressure. | 18 month follow-up fewer students initiated sex in intervention group.<br>Concern: Emphasis on postponing sex. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Jemmott, J.B., Jemmott, L.S., et al. (1992) Reductions in HIV risk-associated sexual behaviors among black male adolescents: Effects of an AIDS Prevention Intervention. *American Journal of Public Health* 82(3): 372-377 | | |
| POC/ Youth (African Am) | 157 participated in 5-hour intervention based on theory of reasoned actions. Intervention provided information, video, games, exercises, and skills building. The control group received an intervention on career opportunities. | 3 mo. follow-up, fewer sexual partners in intervention group, more condom use and less anal intercourse. Cost-effectiveness data: Pinkerton SD, Holtgrave DR, and Jemmott JB (2000). Economic Evaluation of HIV Risk Reduction Intervention in African-American Male Adolescents. *JAIDS* 25(2): 164-72. |

| Jemmott, J.B., Jemmott, L.S., Fong, G.T. (1998) Abstinence and safer sex HIV risk reduction interventions for African-American Adolescents: A randomized controlled trial. *Journal of the American Medical Association* 279: 1529-36. | | |
|---|---|---|
| African-Am Youth | Randomized controlled trial with 3, 6, and 12 month follow-up. 659 male and female African-American 6th and 7th graders. Eight 1 hour modules, adult facilitators or peer co-facilitators. Abstinence intervention stressed delaying intercourse or reducing frequency; safer sex intervention stressed condom use; control intervention concerned health issues unrelated to sexual behavior. | Abstinence: less likely to report sex at 3 months, but not at 6 or 12 months. Safer-sex: more consistent condom use than control at 3 months and higher frequency of condom use at all follow-ups. Among youth sexually experienced at baseline, safer-sex intervention participants reported less sex at 3 months than the control intervention participants. Additionally, those attending the safer sex intervention reported less sex at 6 months and 12 months than the abstinence and control interventions. No differences in intervention effects with adult facilitators compared with peer co-facilitators. |

| Magura S, Kang S. et al. (1994) Outcomes of Intensive AIDS Education for Male Adolescent Drug Users in Jail. *Journal of Adolescent Health* 15(6): 457-463. | | |
|---|---|---|
| Young POC/ drug users | NYC Department of Corrections Adolescent Reception and Detention Center. 157 youths aged 16-19, most were African-American or Hispanic. 4 1-hour small-group sessions of eight led by male counselor. Sessions focused on health education issues relevant to male adolescent drug users, with an emphasis on HIV/AIDS. Group activities included role-play and rehearsal techniques. | Youth in the intervention were more likely to use condoms during vaginal, oral or anal sex, had fewer high-risk sex partners, and had more favorable attitudes toward condoms than youth not in the intervention.<br>Comment: None of youth admitted to using injection drugs; however, there was a high incidence of crack and intranasal cocaine use. Curriculum focused on sexual risk reduction. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Kalichman, S.C., Cherry, C. and Browne-Sperling, F. (1999) Effectiveness of a Video-Based Motivational Skills-Building HIV Risk-Reduction Intervention for Inner-City African American Men. *Journal of Consulting and Clinical Psychology* 67:959-966. | | |
| African-Am men | 117 heterosexually active African-American men recruited from public clinic. Randomly assigned to either a 6-hr video-based small group motivational-skills intervention or a 6-hr video-based HIV education comparison group. | Men in motivational-skills group decreased rate of unprotected vaginal intercourse and used more condoms at 3 months. Both groups showed increased condom use at 6-month follow-up. |

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| Kelly, J.A., Murphy, D.A., et al. (1994) The effects of HIV/AIDS Intervention Groups for High-risk Women in Urban Clinics. *American Journal of Public Health* 84(12): 1918-1922 | | |
| Women (African-Am) | 197 women at urban primary care clinic randomly assigned to intervention or control. Intervention included four 90 min group sessions and 1-month group follow-up with 8-10 women in-group with two leaders. Provided information, role-plays, managing 'triggers', group problem solving and active support. Comparison group attended sessions on health topics unrelated to AIDS. | At 3-month follow-up, intervention group had increased communication and negotiation skills, decreased UVI, and increased condom use. Control group showed no change.<br>Concern: short follow-up |

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|---|---|---|
| Kirby, D., Barth, R.P., et al. (1991) Reducing the Risk: Impact of a new curriculum on sexual risk taking. *Family Planning Perspectives* 23(6): 253-263. | | |
| Youth | A school-based program conducted over 15 classroom periods. 758 students were assigned to a treatment or control group. The treatment group received the Reducing the Risk curriculum that was based on several somewhat interrelated theoretical approaches. Those assigned to the comparison group received a mandatory health education class. | Intervention group had prolonged first onset of intercourse than control group. After 18 months, 29% of the intervention group had initiated intercourse compared with 38% of the control group. Outcomes regarding unprotected sex refer generally to birth control, not specifically to condoms.<br>Concerns: Small effect, if any, for high-risk sexually active youths. Setting specific? |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Levy, J.A., Fox, S.E. (1998) The Outreach-assisted Model of Partner Notification with IDUs. *Public Health Report* 113(S-1): 160-9. | | |
| Youth | School-based program with 15 school districts randomly assigned to 3 conditions a) parent interactive; b) parent non-interactive and c) wait list. Intervention was lecture, small group discussion, and skills building to: resist social pressures; obtain preventive practices, role-play, practice, and homework. 10 session provided to 7th graders and 5 sessions provided to the 8th graders. | Intervention groups use of condoms and foam from 14% to 24%. Had sex less often. No difference in use of condoms alone.<br>Concern: Setting specific? |

| Main, D.S., Iverson, D.C., et al. (1994) Preventing HIV Infection Among Adolescents: Evaluation of School-Based Education Programs. *Preventive Medicine* 23(4):409-417. | | |
|---|---|---|
| Youth | School-based program conducted over 15 sessions (40 hours). Program consist of 3 HIV knowledge sessions, 2 normative determinates of risky behavior, one on teen vulnerability and eight on development skills to identify and manage risking situations. | At 6-month follow-up, sexually active students reported significantly fewer partners and greater frequency of condom use.<br>Concern: Setting specific? |

| Malow, R.E., West, J.A., et al. (1994) Outcome of Psychoeducation of HIV risk reduction. *AIDS Education and Prevention* 6(2): 113-125. | | |
|---|---|---|
| POC/ Drug use (African American cocaine users) | 152 African American males at in-patient tx program participated in group-level sessions. Non-peer led, held for 2 hours over 3 consecutive days, 6-8 people. Sessions included HIV knowledge/risk; demonstrated cleaning works; condom use, condom negotiating, and skills-building exercises; and review and discussion of HIV testing procedures. | 47.5% of intervention group participants reported having more than one partner at three-month follow-up compared to 76% at the baseline in the comparison group. The change from 76% at baseline to 59% at the follow-up was considered to be not statistically significant. Sexual risk taking in those receiving the intervention decreased from 75% (pre intervention) to 32% (follow-up). |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| The National Institute of Mental Health (NIMH) Multisite HIV Prevention Trial Group (1998). The NIMH Multisite HIV Prevention Trial: Reducing HIV sexual risk behavior. *Science* 280: 1889-94. | | |
| POC | Project Light. (www.cdc.gov/hiv/projects/rep/light.htm) Randomized, controlled trial with 3 high-risk populations at 37 inner city, community-based clinics at 7 US sites. 1855 control and 1851 intervention participants, mostly African-American or Hispanic. Experimental condition: Small-group (5-15), twice weekly 7 session program, 90-120 minutes per session. Separate male and female groups. Co-led by a male and a female facilitator. Control condition: 1-hour AIDS education session that included videotape and Q&A period. | Both groups decreased frequency of unprotected sex at follow-up. Compared to controls, intervention group reported fewer unprotected sexual acts, had higher levels of condom use, and were more likely to use condoms consistently over a 12-month follow-up period. In intervention group, more sessions attended associated with greater behavior change. No difference in overall STD reinfection rate. Among men recruited from STD clinics, lower gonorrhea incidence at follow-up. |

| Nyamathi, A.M., Flaskenis, J., et al. (1994) Evaluation of Two AIDS Education Programs for Impoverished Latina Women. *AIDS Education and Prevention* 6(4): 296-309. | | |
|---|---|---|
| POC Women drug using/ homeless | The purpose was to evaluate and contrast the effectiveness of two culturally sensitive AIDS education programs. 131 women participated in the traditional program where they received one hour of AIDS education and community resource information. 82 women participated in a specialized program where the information was extended to include reinforcement of risk skills and enhancement of self-esteem and control. | Over the two-week interval, significant improvements were found in both groups for all cognitive and psychological variables, except problem-focused coping. High-risk IV drug use (in those who reported this behavior during the pre test) decreased from 18 to 7 in the traditional group and from 14 to 0 in the specialized group. Likewise, reports of non-IV drug use and sexual activity with multiple partners decreased in both groups. Concern: Very short follow-up. |

| O'Donnell, C.R., O'Donnell, L., et al. (1998) Reductions in STD infections subsequent to an STD clinic visit: Using video-based patient education to supplement provider interactions. *Sexually Transmitted Diseases* 25(3): 161-168. | | |
|---|---|---|
| POC/ African Am and Hispanic males<br><br>*"VOICES /VOCES"* | 2,004 adult males in South Bronx, New York. Tested video-based STD prevention. Random assignment to three groups: video plus discussion, video only, usual clinic services (control). Interactive session was small group format (three to eight patients) at the clinic and facilitated by an STD counselor. Two culturally sensitive videos (Let's Do Something Different for African Americans and Porque Si for Hispanics) were used.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | Men who participated in experimental groups had significantly lower rates of new STD infection than those in comparison group. No difference between video only group and video plus discussion group. Clients with multiple sex partners experienced greatest effect. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Raj, A., Amaro, H., Cranston, K., et al. (2001). Is a General Women's Health Promotion Program as Effective as an HIV-Intensive Prevention Program in Reducing HIV Risk Among Hispanic Women? *Public Health Reports* 116: 599-607. | | |
| Latina | Study included 162 Hispanic women ages 18 to 35, most of them low-income immigrants, in Boston area. Assessed whether participation in an HIV intensive prevention program or in a general women's health promotion program led to greater risk reduction than being in the wait-list control group. Both interventions lasted 12 weeks (12 sessions of 90-120 minutes each) and were group-level interventions. | Measurements at baseline, intervention completion, and 3 months. Both interventions showed increased condom use at post-test and follow-up. HIV intensive program participants also reported increased safer sex negotiation. Health promotion program participants reported increased HIV testing. |

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|---|---|---|
| Rhodes, R., Wolitski, R.J., et al. (1992) An experiential program to reduce AIDS risk among female sex partners of injection drug users. *Health and Social Work* 17:261-272. | | |
| Women (Sex partners of IDUs) | 69 women recruited though street outreach participated in 3 90-min group sessions held on consecutive days then a fourth session one week later and underwent HIV C/T. Sessions focused on AIDS education, condom use, needle cleaning, negotiation, problem-solving skills building; referrals; and post-intervention weekly support groups. | At immediate post-intervention, 91% reported having made positive changes to reduce AIDS risk and 68% of women who did not use condoms before intervention reported they had since entering intervention (No control). |

| | | |
|---|---|---|
| Rotheram-Borus, M.J., Koopman, C., et al. (1991) Reducing HIV sexual risk behaviors among runaway adolescents. *Journal of American Medical Association* 266(9): 1237-1241. | | |
| POC/ Youth<br><br>*"Street Smart"* | Non-random control 197 runaways. Small group sessions 90-120 min., 4 days/week. Each up to 30 sessions at least 3 private session, develop soap opera dramas, review videos, and skills coping.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | 3 and 6-month follow-up. Increased number of sessions associated with increased condom use, and decreased risk behaviors. An update of the intervention in 1997 CDC compendium shows similar results. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Schilling, R.F., EL-Bassel, N., et al. (1991) Building Skills of Recovering Women Drug Users to Reduce Heterosexual AIDS Transmission. *Public Health Reports* 106(3): 297-304. | | |
| Women/ POC | 91 African-American and Hispanic women enrolled for at least 3 months in five clinics in large methadone maintenance program in NYC. Non-peer led skills-building groups held five 2-hour sessions offered to groups of 9-10. Topics included: HIV 101; identification of high-risk sexual practices; discussion of barriers to adopting safer sex practices; discussion of negative associations with condoms; condom use skills; role-played negotiation of condom use; assertiveness; problem solving; and communication skills involving safer sex scenarios. Comparison group received one session of AIDS information routinely provided by the clinic. | The skill-building intervention group showed statistically significant higher use of condoms than those in the control group at follow-up. Participants also more comfortable taking and carrying condoms, talking about safer sex with partners, had more favorable attitudes toward condoms. No drug use differences between groups.<br>Comment: Initial follow-up was 2-week post. |

| Schilling, R.F., Ivanoff, A., et al. (1994) HIV-related risk reduction among women offenders in jail and in the community. *X International Conference on AIDS.* 10,43 | | |
|---|---|---|
| Women/ Drug Use | 159 Drug-abusing female offenders, approaching release from a 3-12 month sentence, were recruited from Rikers Island. Women were randomly assigned to (1) 8 group session conducted in prison and 8 individual session in the community post-release, focussing on AIDS information; condom use; needle-cleaning; and negotiation skills building and social support; or (2) information-only. | At follow-up, there was a trend for intervention participants to report greater condom use improvements. |

| Sikkema, K.J., Winett, R.A., et al. (1995) Development and Evaluation of an HIV-Risk Reduction Program for Female College Students. AIDS Education and Prevention 7(2): 145-159. | | |
|---|---|---|
| College women | 43 heterosexual college women participated in four 75 to 90-min. sessions held over a one-month period with groups of seven to 10 participants. Female doctoral students served as group mediators. The intervention covered topics such as risk behavior education, behavioral self-management, assertiveness training, decision-making, safer sex negotiation, condom use and maintenance of risk-reduction behavior. The control group received one 90-min. session covering the same topics but using a didactic education approach. | The intervention was effective at improving one key determinant of sexual risk behavior: sexual assertiveness and communication skills. The skill-building participants showed greater improvement from baseline to the immediate follow up in overall assertiveness skill, in the sum of four components of skill and in two of the four components: acknowledgment of partners' request for sex and suggestion of alternative lower-risk behavior.<br>Concern: Applicability of results to other (non-college, high-risk) populations. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Shain, R.N., Piper, J.M., Newton, E.R., et al. (1999) A randomized, controlled trial of a behavioral intervention to prevent sexually transmitted disease among minority women. *New England Journal of Medicine* 340: 93-100. | | |
| Women of Color | 424 Mexican-American and 193 African-American women with nonviral STDs. Randomized trial. Intervention 3 weekly small-group sessions, 3-4 hours each. 5-6 women per group and female facilitator, all of same race/ethnicity. Sessions designed to help recognize personal susceptibility, commit to changing behavior, and acquire skills. Based on AIDS Risk Reduction Model. 6 and 12 mo follow-up. | High rates of session attendance and retention in study. This intervention decreased the rates of Chlamydia and gonorrheal infection among Mexican-American and African American women at high risk for sexually transmitted disease; rates of subsequent infection was significantly lower in intervention group at both follow-ups.<br>Comment: Very strong study design. |

| Stanton, B.F., Li, X., et al. (1996) A Randomized, Controlled Effectiveness Trial of an AIDS Prevention Program for Low-Income African-American Youth. *Archives of Pediatrics and Adolescent Medicine.* 150(4): 363-372. | | |
|---|---|---|
| African-Am youth | Public Housing developments/rural campsites. 383 African-American youth, 9 to 15 years of age, in peer groups. 7 weekly sessions (1- ½ hour each) and one day-long session. Each session led by a pair of interventionists, recruited from the community, most of whom were African-American. Group sessions included communication and negotiating skills, value clarification, goal setting and peer norms. Small-group discussions, lectures, videos etc. In session 7 the group developed community projects with intervention messages. | Condom use in the short term (6 month after intervention) showed significant improvement for intervention youth compared with control youth. Long-term follow-up (2 years) showed that intervention youth were less likely than control youth to adopt a risk behavior, though they were not less likely to experiment with a risk behavior.<br>Concern: Condom use difference disappeared at 12-month follow-up. |

| Walters, H.J., Vaughn, R.D. (1993) AIDS risk reduction among a multi-ethnic sample of urban high school students. *Journal of American Medical Association* 270(6): 725-730. | | |
|---|---|---|
| POC/ Youth | School-based program with two intervention schools and two comparison schools, 1316 students. Six 1-hour lessons on AIDS facts, risk appraisal, personal values, norm change, role-play, negotiating skills, and how to use condoms. | At the three-month follow-up, significant efforts in five of the eight variables (knowledge, benefits, norms, self-efficacy and behaviors) favored those students who participated in the intervention. The intervention appeared to have the greatest effect on involvement in sexually intercourse, was associated with favorable tends in STD rates, but did not effect sexual abstinence.<br>Concern: Setting specific? |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| St. Lawrence, J.S., Brasfield, T.L., et al. (1995) Cognitive-behavioral Intervention to Reduce African-American Adolescents' Risk for HIV Infection. *Journal of Consulting and Clinical Psychology* 63(2): 221-237. | | |
| POC/ Youth (African-Am) | Public health clinic serving low-income families in a mid-size southern US city. 246 inner-city youth ages 14-18. Intervention was 8 group sessions (1½ to 2 hours each) of 5 to 15 participants. Group sessions were co-led by trained facilitators. The group members used role-playing techniques and practiced skills-building activities in smaller groups of two to three persons. Sessions included HIV/AIDS education; peer pressure and sexual decision making; communication and assertiveness skills-building activities; meeting an HIV positive youth; discussion on the most beneficial components of the intervention and how they increased self-efficacy. Control group received 2 hours of education. | Male and female adolescents who received the intervention increased condom use significantly. The males in the group also lowered their rates of unprotected intercourse to a greater extent than did males in the information-only intervention. The females, who received skills training, compared with those who received information only, decreased the frequency of unprotected intercourse. Thus, the skills training intervention was more successful both in lowering risky behaviors and in sustaining safe alternatives such as condom use among youth who remained sexually active. |

| St. Lawrence, J.S., Brasfield, T.L., and O'Bannon, R.E. (2002). Reducing STD and HIV Risk Behavior of Substance-Dependent Adolescents: A Randomized Controlled Trial. *Journal of Consulting and Clinical Psychology* 70(4): 1010-1021. | | |
|---|---|---|
| Youth | Conducted in Mississippi with high-risk adolescents in two residential drug treatment programs. Assessed 3 interventions designed to increase safer sex behaviors of substance-dependent adolescents. Mixed gender cohorts of 6 to 10 adolescents met three times each week over a 4-week period for a total of twelve 90-minute sessions. Total N=161 participants (68% male, 75% white, 22% African American). Randomly assigned to either a health information intervention (I only); information plus behavioral skills safer sex training (i.e., correct condom use, partner negotiation, refusal of unwanted sexual invitations, and peer information provision) (I+B); or the same experimental condition plus a motivation component that confronted adolescents' illusion of invulnerability and then emphasized their ability to prevent the negative outcome (I+M+B). The intervention conditions were in addition to the existing drug treatment programs. | Assessments at baseline, 6 months, and 12 months. The I+B and I+M+B conditions, as compared with the I only condition: (a) produced more favorable attitudes toward condoms; (b) reduced the frequency of unprotected vaginal sex; and (c) increased behavioral skill performance, frequency of condom-protected sex, percentage of intercourse occasions that were condom protected, and number of adolescents who abstained from sex. The I+M+B intervention was more resistant to decay. |

# Effective Interventions for Heterosexuals

| **Group-Level (cont.)** | | |
|---|---|---|
| Wenger, N.S., Greenberg, J.M., et al. (1992) Effect of HIV Antibody Testing and AIDS Education on Communication About HIV Risk and Sexual Behavior. *Annals of Internal Medicine* 117(11): 905-911. | | |
| College students | 435 university students at outpatient student health clinic. Consisted of a multimedia presentation in a single 1-hour small-group session. Led by physicians familiar with HIV counseling. The session began with an 11 min video, 15 min scripted lecture (AIDS 101, routes of transmission, and safer sex behaviors, obstacles to using condoms, communication with sex partners, and the role of drugs and alcohol in promoting unsafe sex behaviors). Following the lecture, participants engaged in 15 minutes of role-play and 15 minutes group discussion. Students randomly assigned to get HIV testing. | After 6 months, heterosexual university student who received education about HIV infection plus HIV testing were more likely compared with students in the control group to increase communication with their sexual partners about the risk of HIV infection. No difference in condom use or number of sexual partners.<br>Concern: Applicability of results to other (non-college, high-risk) populations. |

| **Prevention Case Management** |
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| The CDC has endorsed Prevention Case Management (PCM) as an effective intervention to reach HIV positive and/or very high-risk HIV negative persons. PCM is a client-centered HIV prevention activity with the fundamental goal of promoting the adoption and maintenance of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. PCM provides client-centered, multiple-session HIV risk reduction counseling while using the service brokerage of traditional case management to address competing needs that may make HIV prevention a lower priority. This HIV prevention activity addresses the relationship between HIV risk and other issues such as substance use, mental health, adherence issues, social and cultural factors, and physical health problems. While PCM has yet to be rigorously evaluated, intensive case management interventions for clients with multiple, complex problems have been shown to be effective in other health fields. **CDC PCM Guidance September 1997** http://www.cdc.gov/hiv/pubs/pcmg/pcmg-doc.htm. **Literature Review** – www.cdc.gov/hiv/pubs/pcml/pcml-doc.htm. **Acronyms** – www.cdc.gov/hiv/pubs/pcmg/pcmg-acr.htm |

# Effective Interventions for Heterosexuals

| **Community-Level** | | |
|---|---|---|
| The CDC AIDS Community Demonstration Projects Research Group (1999) Community-level HIV intervention in 5 Cities: Final outcome data from the CDC AIDS Community Demonstration Projects. *American Journal of Public Health* 89: 336-45. | | |
| Multiple sub-pops | Role model stories distributed with condoms and bleach by community members who encouraged behavior change. Quasi-experimental design. Over 3 years, 15,205 interviews conducted with 10 intervention and comparison community pairs. Outcomes measured on stage-of-change scale. Sub-populations: IDUs, their female sex partners, sex workers, non-gay identified MSM, high-risk youth, residents of areas with high STD rates. | By end of intervention, 54% of persons interviewed in intervention communities had been exposed to materials in past 3 months. Consistent condom use with main and non-main partners, especially for vaginal intercourse, and increased condom carrying, greater in intervention communities. At individual level, respondents recently exposed to intervention more likely to carry condoms and to have higher stage-of-change scores for condom and bleach use. |

| Lauby, J.L., Smith, P.J., Stark, M., et al. (2000) A community-level HIV prevention intervention for inner-city women: Results of the Women and Infants Demonstration Projects. *American Journal of Public Health* 90 (2): 216-222. | | |
|---|---|---|
| Women (mostly African-American)<br><br>*"Real AIDS Prevention Project (RAPP)"* | Low-income, primarily AA women in 4 urban communities. Pre-post surveys in matched intervention and comparison communities. Targeted sexually active. Activities: development and distribution of prevention materials, mobilization of peer network of community volunteers, delivery of prevention messages by trained outreach specialists through individual contacts and small-group activities. Role model stories. A total of 225-240 women interviewed in each intervention and comparison community in each wave of survey.<br><br>This intervention was outlined in CDC's *Procedural Guidance* for selected strategies and interventions for CBOs under Program Announcement 04064. | After 2 years, significant increase (11%) in rates of talking with main partner about condoms, also significant increase (13%) in proportion who had tried to get main partners to use condoms. Almost significant (p=054) decrease (9%) in never using condoms. Effects stronger for women who reported exposure to intervention. No intervention effects for condom use during most recent sex or for consistent condom use, but both groups increased over time. Trends for condom use for other partners similar but not significant. |

# Effective Interventions for Heterosexuals

| **Community-Level (cont.)** | | |
|---|---|---|
| Sellers, D., McGraw, S., et al. (1994) Does the promotion and distribution of condoms increase teen sexual activity? Evidence form an HIV prevention program from Latino youth. American Journal of Public Health 84(12): 1952-1959. | | |
| POC/ Youth (Latinos) | The purpose of the study was to see if condom distribution increases sexual activity. Boston was the intervention city and Hartford was the comparison city. The intervention included condom distribution, workshop in schools, group discussion, large community events, presentations, and door-to-door street outreach. | Males, in the intervention city wee less likely to initiate first sexual activity. Females were less likely to have multiple sex partners. Conclusion: HIV prevention programs that include condom distribution did not increase sexual activity.<br>Concern: Applicability. |

| Sikkema, K.J., Kelly, J.A., Winett, R.A., et al. (2000) Outcomes of a randomized community-level HIV prevention intervention for women living in 18 low-income housing developments. *American Journal of Public Health* 90: 57-63. | | |
|---|---|---|
| Low-income women | 690 low-income women living in 18 housing developments. Community-level intervention in 5 US cities. HIV risk reduction workshops and community prevention events implemented by women who were popular opinion leaders. | At 12-month follow-up, proportion of women who had any UI decreased and percentage of protected sex acts increased in intervention group. Little behavior change in control group. |

| Tross, S., Abdul-Quader, A.S., Simons, P.S., Sanchez, M., Silvert, H.M. (1993). Evaluation of a peer outreach HIV prevention program for female partners of injecting drug users (IDUs) in New York City. *IX International Conference on AIDS*. Berlin, June 1993 [abstract PO-D13-3737]. | | |
|---|---|---|
| Female sex partners (FSPs) of IDU | 658 FSPs in high drug-use housing project in NYC randomly assigned to intervention or control. Intervention was peer outreach and media distribution program. | Significant increase in percentage of intervention group always using condoms and decrease in percentage never using condoms. No change in control group.<br>Comment: Information from abstract only so few details available. |

| Vincent, L., Clearie, A., et al (1987) Reducing adolescent Pregnancy through school and community-based education. *Journal of American Medical Association 254(4): 3382-3386* | | |
|---|---|---|
| POC/ Youth | Intervention to reduce adolescent pregnancies. Three-hour courses for teachers. Sex education in all grades. Training for clergy, church leaders and parents. Mass media speakers. | 2-year follow-up. Pregnancy rates decreased by half in target county only.<br>Concern: Applicability. |

# Effective Interventions for Heterosexuals

| **HIV Antibody Counseling & Testing** CDC Revised Guidance for HIV Counseling, Testing, and Referral. MMWR 2001, 50 (RR-19); 1-58 (http://www.cdc.gov/mmwr/pdf/rr/rr5019.pdf | | |
|---|---|---|
| Bevier, P., Ewing, W., et al. Effects of counseling on HIV risk behaviors in patient at a New York City sexually transmitted disease clinic. *VII International Conference on AIDS* 7, 458. | | |
| Women (STD clients) | 1016 total STD clinic patients received one-session of HIV risk behavior counseling. Total percentage of women unknown. | At 6-month follow-up, women significantly reduced their total number of partners from 5.9 to 4.3 in a 6-month period. Condom use 'increased slightly', but sex partners of IDs reported condom use only 10% of the time. |

| Corby, N., Barchi, P., et al. (1990) Effects of condom skills training and HIV testing on AIDS prevention behaviors among sex workers. *VI International Conference on AIDS.* 6, 267. | | |
|---|---|---|
| Sex workers | 64 sex workers were randomly selected into four groups. Group 1: HIV counseling/testing. Group 2: 15-min. AIDS prevention program with rehearsal of condom use. Group 3: both 1 & 2. Group 4: No intervention | At 1-month follow-up, women in group 3 showed increase in condom use during vaginal intercourse with customers. Women in group 1 reported a decrease in proportion of condom us during oral sex with customers. |

| Higgins, D.L., Galavotti, C., et al. (1991) Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *Journal of American Medical Association* 266(17): 2419-2429. | | |
|---|---|---|
| General | A review of 10 studies on the effects of C/T on behavior change (condom use, reduction of sexual partners) of heterosexuals (actual study reviews several populations). | Of the studies: 80% showed increase in condom use; 30% showed increase in safer sex (undefined) and 1% showed decrease in sexual partners (Note: most were measuring for condom usage – 1% may not be reflective of real change). |

| Kamb, M.L., Fishbein, M., et al. (1998) Does HIV/STD Prevention Counseling Work? Results From a Multicenter, Randomized Controlled Trail Evaluating Counseling Among STD Clinic Patients (Project RESPECT). *Journal of American Medical Association 280: 1161-1167. (*Project Respect - www.cdc.gov/hiv/projects/rep/RESPECT.htm) | | |
|---|---|---|
| General | Project Respect. Five publicly funded STD clinics located in US inner cities (Baltimore, Denver, Long Beach, Newark and San Francisco). 5758 heterosexual HIV negative men and women who initially came to the clinics for STD diagnosis and treatment. Three face-to-face interventions: enhanced counseling (3-hours interactive sessions), brief counseling (2 40-minutes interactive session) and didactic message (personalized 10-minutes informational messages about HIV/STD prevention). | 3 and 6-month follow-up visits, any condom use and consistent condom use were significantly higher among participants in both enhanced and brief counseling compared with control. Through the 6-month interval, 30% fewer participants had new STDs compared with control. Through 12 months, 20% fewer participants in each counseling intervention had new STDs compared with didactic group.<br>Comment: Supported by Branson et al. (1998) *Sex Transm Dis* 25: 553-559. |

# Effective Interventions for Heterosexuals

| **HIV Antibody Counseling & Testing (cont.)** | | |
|---|---|---|
| Higginbotham, S., Holmes, R., Stone, H., Beil, J., Datu, Costa, S., G.B., Paul, S., (2000) Adoption of Protective Behaviors Among Persons With Recent HIV Infection and Diagnosis--- Alabama, New Jersey, and Tennessee, 1997--1998. *MMWR June 16, 2000/*49(23); 512-515 | | |
| | To examine risk behaviors (e.g., condom use and number of sex partners) after HIV diagnosis, CDC analyzed data on HIV Testing history and sexual behavior of persons who may have recently acquired HIV infection as part of a CDC sponsored study in Alabama, New Jersey, and Tennessee. For purpose of the study, criteria for recent HIV infection included persons with diagnosed and reported HIV infection with CD4 T-lymphocyte counts >700 cells/ul or percentage>36, documented HIV seroconversion within 18 months of confirmed HIV infection diagnosis, or persons aged 13-24 years when diagnosed. During January 1997 through September 1998, 615 persons with HIV infection diagnosed and reported met the criteria for the study. These persons represented 15% of all persons reported with HIV in the three states. Prior to diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males 25% reported never using a condom, 69% reported sometimes using a condom, and 6% reported always using condoms. | Of the 543 persons eligible after follow-up, 180 persons completed the interview within 12 months of the self-reported date learning they were HIV infected (median: 6 months). Among those, 99 (55%) were female; 96 (53%) were <25 years old; and 105 were non-Hispanic blacks, 49 were non-Hispanic white, 24 were Hispanic, and two self reported as "other". 162 (90%) responded that they had changed their behavior since learning of their HIV infection. After diagnosis, the females reporting having vaginal sex with males and males reporting anal sex with males, 30% reported not having sex, 6% reported never using a condom, 11% reported sometimes using a condom, and 47% reported always using condoms. The number of sexual partners for the males and females decreased as well. |

| **Partner Notification - CDC Guidance -** www.cdc.gov/hiv/partners/interim/partnercounsel.htm<br>**Procedural Guidance Intervention –** http://www2a.cdc.gov/hivpra/documents/Attachments/cbofinal/Pages from CBOProcedures_15Dec03_FinalDraft_10.pdf | | |
|---|---|---|
| Jordan, W.C., Tolbert, L. (1998) Partner Notification and Focused Intervention as a Means of Identifying HIV-positive Patients. *Journal National Medical Association* 90:542-6. | | |
| General | Los Angeles. 22 of 22 women, 5 of 8 heterosexual men and 6 of the 44 MSM interviewed were able to provide locating information on all of their enumerated/reported partners. Intervention divided MSM into two focus groups. Group 1 was asked: Who do you know that's HIV positive and still practicing unsafe sex? Group 2 was asked: Who do you know that's HIV positive but not in treatment? | 13 of the 14 MSM in group 1 were able to identify 30 person they felt were still practicing unsafe sex; 17 of the 30 tested HIV positive and 9 were unaware of their status. Group 2 identified 15 people they felt were HIV positive. 11 were found to be HIV positive and 8 were unaware of their status. |

# Effective Interventions for Heterosexuals

| **Partner Notification (cont.)** | | |
|---|---|---|
| Landis, S.E., Schoenback, V.J., et al. (1992) Results of a Randomized Trail of Partner Notification in Cases of HIV infected in North Carolina. *New England Journal of Medicine* 326:101-6. | | |
| General | North Carolina. Three local health departments. 162 participated, 54% declined and 46% agreed. 39 assigned to provider referral, 35 to patient referral. | In provider referral, 70 of 157 partners were successfully notified; patient referral, 10 of 153 notified. 23% of partners notified and tested were positive. |

| Pavia, A.T., Benyo, M., et al. (1993) Partner Notification for control of HIV: Results after 2 years of a Statewide Program in Utah. *American Journal of Public Health* 83:1418-24. | | |
|---|---|---|
| General | Utah. All persons reported in state over 2 years (308) 79% cooperated with 890 named partners with 70% located. | Of those located 34% were previously positive. Of the remaining 2763 tested, 14% newly identified as infected. IDU, women and confidential (vs. anonymous) testers were more likely to cooperate and reported more partners. Cost: about $3,000 per new infection identified. |

| Rutherford, G.W., Woo, J.M., et al. (1991) Partner Notification and the Control of Human Immunodeficiency Virus Infection. Two year of experience in San Francisco. *Sexually Transmitted Disease* 18:107-110. | | |
|---|---|---|
| General | San Francisco. 51 interviewed AIDS patients named 135 opposite-sex partners. | 44%of partners located and interviewed, 25% tested, 5% HIV infected. Cost: $454 per partner notified. $2,203 per positive identified. |

| Toomey, K.E., Peterman, T.A., et al. (1998) Human Immunodeficiency Virus Partner Notification Cost and Effectiveness Data From an Attempted Randomized Controlled Trial. *Sexually Transmitted Disease* 25:310-6. | | |
|---|---|---|
| General | New Jersey and Florida. 8 partners reported per case, one located per case. | 25% previously positive. 75% of the remainder were tested. 22% positive. New positive partners per original case: 0.1. Cost: $250/index patient; $427 partner notified; $2,200 new infection identified. |

| Partner Counseling and Referral Services to Identified Persons with Undiagnosed HIV---North Carolina. *MMWR* December 5, 2003/52 (48); 1181-1184 | | |
|---|---|---|
| | In 1989, North Carolina Department of Health and Human Services began offering PCRS to clients who tested positive in confidential and anonymous testing venues. HIV infection became reportable in 1990 and anonymous testing was discontinued in 1997. A trained disease intervention specialist (DIS) completed six important steps. All notified partners received risk reduction counseling and appropriate referrals. | Data collected from 2001 revealed a total of 1,603 persons were newly reported to have HIV infections. DIS were assigned to conduct PCRS with 1,580 (99%) index clients, 1,378 (87%) were located and PCRS identified 1,532 sex or needle sharing partners. 1,359 partners were located and notified of their possible exposure to HIV. After PCRS, from those who not previously testing positive for HIV, 108 newly tested partners were diagnosed HIV positive. |

# Effective Interventions for Heterosexuals

| **Drug Treatment** | | |
|---|---|---|
| Shoptaw. S., Frosch, D., Rawson, R.A., Ling, W. (1997). Cocaine Abuse Counseling as HIV Prevention. *AIDS Education and Prevention* 9(6): 511-520. | | |
| Non-IDU drug users | Evaluated the efficacy of cocaine abuse counseling alone as a strategy to reduce HIV related sexual risk behaviors. Participants were 232 cocaine-abusing or dependent individuals who received up to 26 weeks of Matrix counseling but no formal HIV prevention interventions. 157 (67.6%) participants completed assessments at admission, during treatment, and at 6 months following admission. Participants located for follow-up were significantly more likely to be Caucasian, to be better educated, and to complete longer treatment episodes than those not located. Demographics: mostly heterosexual (89.9%), Caucasian (69.0%), crack cocaine users (65.6%). | Main study findings indicated a significant association between safer sex behavior and completion of a cocaine abuse counseling episode. Participants who completed counseling were more likely to change to safer sex or maintain safer sex over the 6-month period than participants who terminated counseling prematurely. The primary method for reducing sexual risk involved overall decreases in reported numbers of partners (avg. at baseline = 5.32, avg. at 6-month follow up = 2.47) |

| Shoptaw, S., Reback, C.J., Frosch, D.L., Rawson, R.A. (1998). Stimulant Abuse Treatment as HIV Prevention. *Journal of Addictive Diseases* 17(4): 19-32. | | |
|---|---|---|
| Non-IDU drug users | Individuals who use illicit stimulants, primarily cocaine and methamphetamine, engage in substantial amounts of HIV related sexual risk behaviors when under the influence. This paper presents the idea that reductions in stimulant use consequent to drug treatment makes stimulant drug treatment an important HIV prevention tool for this high–risk population. | Presents data to describe HIV related sexual risks reported by out–of–treatment methamphetamine users and by cocaine and methamphetamine abusers at treatment entry and six months post treatment entry. Overall, findings demonstrate that following initiation of a treatment episode, stimulant abusers demonstrate significant reductions in HIV related sexual behaviors, primarily by reducing the number of sexual partners. |

**No reviews on Mass & Other Media, Social Marketing, Hotlines, and Clearinghouse.**

# ATTACHMENTS

**Attachment: 1 Definition of Theories and Models, including core elements**

Theories tell us why people do what they do. Models tell us how they do it. Some theories are applied to specific groups (for example, Latino gay youth). Other theories are applied to large populations (for example, women of child-bearing age). Today, HIV Prevention Programs can draw from many different social and behavioral theories. It is important to remember that it will be extremely rare- if ever- that you will need to sit down and choose between different theories when developing your prevention program. Rather, because your program will be modeled after a specific intervention that has proven to be effective, you only need to refer to the theory that the original intervention was based upon. Your knowledge of theory should be sufficient to design the intervention. If your intervention is based on a specific theory, it is very likely that other theories may influence your intervention. If you formulate your own intervention based on theories alone, it is necessary for you to select the one theory that can be considered the foundation for intervening.

The following are short summaries of common social and behavioral theories, along with the core elements, that effective HIV Prevention Programs have been based upon.

**AIDS Risk Reduction Model**
(http://www3.utsouthwestern.edu/preventiontoolbox/arrm.htm)

The AIDS Risk Reduction Model believes change is a process individuals must go through with different factors affecting movement. This model proposes that the further an intervention helps clients to progress on the stage continuum, the more likely they are to exhibit change. This model includes elements of several other theories/models (health belief model, self-efficacy theory, and psychological theory) and is applicable to sexually active or injecting drug using individuals.

This was developed specifically for the context of HIV perception. Individuals must pass through three stages; **A) Labeling** – one must label their actions as risky for contracting HIV (i.e. problematic). Three elements are necessary 1) knowledge about how HIV is transmitted and prevented, 2) perceiving themselves as susceptible for HIV, and 3) believing HIV is undesirable. **B) Commitment** – this decision-making stage may result in one of several outcome 1) making a firm commitment to deal with the problem, 2) remaining undecided, 3) waiting for the problem to solve itself, or 4) resigning to the problem. Weigh cost and benefits - giving up pleasure (high risk) for less pleasure (low risk). MAJOR FACTORS – 1) response efficacy (effectiveness to change), 2) perceived enjoyment (acts being added or eliminated), 3) self-efficacy and 4) relevant information and social norms. **C) Enactment** – This includes three stages 1) seeking information, 2) obtaining remedies, and 3) enacting solutions.

**Diffusion of Innovation Model**
(http://www3.utsouthwestern.edu/preventiontoolbox/doi.htm)

The Diffusion of Innovation Model looks at how new ideas are communicated to, and accepted by, members of a group or population. The three major components of this theory are **A) Communication Channels** – for dispensing an innovative or new message. **B) Opinion Leaders** – visible, respected people who can assist in dispensing the message. **C) Time and Process** – required to reach community or group. People receive/accept messages at different time intervals.

**Health Belief Model**
(http://www3.utsouthwestern.edu/preventiontoolbox/hbm.htm)

The Health Belief Model maintains that health related behaviors depend on four key beliefs that must be operating for a behavior change to occur. **A) Perceived susceptibility** – personally vulnerable to the condition. **B) Perceived severity** – belief that harm can be done by the condition. **C) Perceived benefits of performing a behavior** – what they are going to get out of the change. **D) Perceived barriers of performing the behavior** – what keeps them from changing.

**Social Cognitive Theory**
(http://www3.utsouthwestern.edu/preventiontoolbox/sct.htm)

The Social Cognitive Theory maintains that behavior changes are dynamic and influenced by personal and environmental factors. People learn new behaviors through direct experience or modeling after others by observation. **A) Outcome expectations** - the extent the person values the expected outcome of a specific behavior. Will it lead to a positive or negative outcome? **B) Self efficacy** – a person's belief about his/her ability and confidence in performing behaviors.

**Stages of Change Model (Transtheoretical Model)**
(http://www3.utsouthwestern.edu/preventiontoolbox/tm.htm)

The Stages of Change Model maintains that behavior change occurs in stages and that movement through the stages varies from person to person. The six stages are: **1) Pre-contemplation** – no intention to change behavior; not aware of risk. **2) Contemplation** - recognizes behavior puts them at risk and is thinking about changing their behavior, but not committed to the behavior change. **3) Preparation** – the person intends to change the behavior sometime soon and is actively preparing. **4) Action** - person has changed risky behavior recently (within the past six months). **5) Maintenance** – person has maintained behavior change for a period longer than six months. **6) Termination** – individuals are presumed to have no intention to relapse and possess a complete sense of self-efficacy concerning their ability to maintain healthy behavior.

**Theory of Reasoned Action**
(http://www3.utsouthwestern.edu/preventiontoolbox/tra.htm)

The Theory of Reasoned Action maintains a person must have an intention to change. Intentions are influenced by two major factors. **A) Attitudes towards the behavior.** 1) Belief in performing the behavior is based on positive or negative outcomes. 2) Evaluation of consequences to performing behavior. **B) Subjective norms about the behavior.** 1) What significant other thinks about performing the behavior. 2) Motivation to perform behavior based on subjective norms.

**Empowerment Theory**
(http://www3.utsouthwestern.edu/preventiontoolbox/em.htm)

The Empowerment Theory maintains people change through a process of coming together to share experiences, understand social influences, and develop solutions to problems. Three core elements of this theory are **1) Populations for change –** individual/group level. **2) Participatory education –** listening, participatory dialogue and action. **3) Focus group strategies –** gathering information and finding solutions with the community.

**Attachment 2: Core Elements of Health Education and Risk Reduction Activities.**
(http://www.cdc.gov/hiv/HERRG/HIV_HERRG.htm)

- State realistic, specific, measurable, and attainable program objectives.
- Identify methods and activities to achieve specific goals and objectives.
- Define staff roles, duties and responsibilities.
- Define population to be served by geographic locale, risk behavior(s), gender, sexual orientation, and race/ethnicity.
- Assure the educational materials and messages are relevant, culturally competent, and language and age appropriate.
- Include professional development for all programs.
- Include written policies and personnel procedures that address stress and burnout.
- Include written procedures for the referral and tracking of clients to appropriate services outside the agency.
- Provide for collaboration with the other local service providers to assure access to services for clients.
- Assure confidentiality of persons served.

**Attachment 3: CDC's Intervention Checklist for all HIV Prevention Programs**

(http://www.cdc.gov/hiv/pubs/hivcompendium/section3.htm)

**Intervention**

- Clearly defined audience
- Clearly defined goals and objectives
- Behavioral/social science theory
- Accurate information about HIV risk behaviors
- Focus on reducing specific risk behaviors
- Opportunities to practice relevant skills

**Implementation**

- Realistic schedule
- Key elements
- Sensitivity to target population
- Trained staff
- Variety of teaching methods
- Information personalized
- Essential HIV messages repeated

**Organization**

- Administrative support
- Sufficient resources
- Program sustainability
- Decision markers are flexible
- Broader context relevant to target population

**Consumer/Participant**

- Intervention meets priorities and needs defined by community
- Audience included in ongoing tailoring
- Intervention as implemented is:
  - Culturally competent
  - Developmentally appropriate
  - Gender specific
- Intervention as implemented is acceptable to participants

**Attachment 4: RESOURCES:**

1. Procedural Guidance for Selected Strategies and Interventions for Community Based Organizations funded under Program Announcement 04064. December 9, 2003 http://www2a.cdc.gov/hivpra/pa04064.html

2. Center for Disease Control and Prevention, Compendium of HIV Prevention Interventions with Evidence of Effectiveness "Intervention Checklist: Elements of successful Programs. A Tool for Assessment of Local HIV/AIDS Intervention" March 1999 www.cdc.gov/hiv/pubs/hivcompendium/section3.htm

3. Evaluation Guidance Handbook: Strategies for Implementing the Evaluation Guidance for CDC funded HIV Prevention Program. March 2002 www.cdc.gov/hiv/aboutdhap/perb/guidance/chapter3.htm

4. CDC HIV Prevention Community Planning Guidance. July 2003 www.cdc.gov/HIV/PUBS/HIV-cp.htm

5. University of Texas Southwestern Medical Center in Dallas website "HIV Prevention Toolbox" http://www3.utsouthwestern.edu/preventiontoolbox/

6. Guidelines for Health Education and Risk Reduction, Centers for Disease Control and Prevention. April 1995 www.cdc.gov/hiv/HERRG/HIV_HERRG.htm